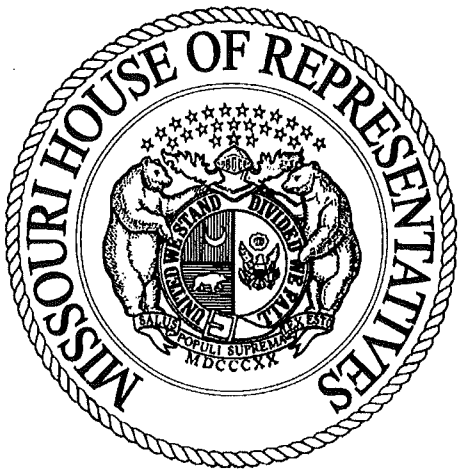


UPDATED

Report of the House of Representatives Citizens and Legislators Working Group on Medicaid Eligibility and Reform

October 2013

October 16, 2013

Chairman Jay Barnes
Interim Committee on Medicaid Transformation
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Dear Chairman Barnes:

The House of Representatives Citizens and Legislators Working Group on Medicaid Eligibility and Reform has met and taken testimony on the current state of Missouri's Medicaid system. Attached is a summary of testimony from each hearing, as well as information provided to the committee by the Department of Social Service and updated appendices.

Sincerely,

Representative Noel Torpey
Committee Chair

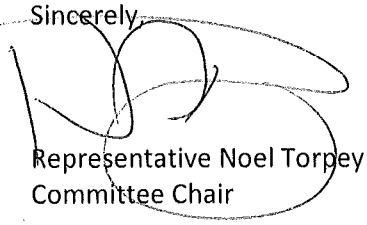
October 16, 2013

Tim Jones, Speaker
House of Representatives
State Capitol Building
Jefferson City, MO 65101

Dear Mister Speaker:

The House of Representatives Citizens and Legislators Working Group on Medicaid Eligibility and Reform has met and taken testimony on the current state of Missouri's Medicaid system. Attached is a summary of testimony from each hearing, as well as information provided to the committee by the Department of Social Service and updated appendices.

Sincerely,



Representative Noel Torpey
Committee Chair

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Summary of Public Testimony

I. July 10, 2013 Hearing

At the July 10 hearing in Independence, the working group heard testimony on the history of Medicaid, MO HealthNet basics, an overview of United States health systems, the state of Missouri's health, and the significance of Missouri's uninsured.

Witnesses discussed the challenges currently faced by safety net hospitals, including funding and revenue changes, and how safety net institutions are changing their approach to patient care to increase quality of care and improve health outcomes. The witnesses spoke to the lack of mental health beds available in Missouri and the need for better funding of behavioral health services in Missouri and nationwide.

Witnesses discussed the need for expansion of Medicaid services to provide health care to adults with low-wage jobs and small business employees who are not provided the opportunity to purchase health insurance through an employer.

The working group also heard testimony from the Department of Social Services, who testified for informational purposes only. Information provided by the department is attached in Appendix 1(a).

II. July 16, 2013 Hearing

At the July 16 hearing in Springfield, the working group heard testimony on eligibility and enrollment requirements for MO HealthNet.

Witnesses discussed the need to reform the current Medicaid system to make the program more effective and improve health care outcomes for enrollees. Witnesses expressed concerns with managed care for behavioral health services. Witnesses spoke to the benefits of providing behavioral health services in a health care home setting, where a primary care provider leads a health care team to provide comprehensive and continuous medical care to patients. Witnesses testified to the need for the health care home model to continue for behavioral health services, as well as the need for better mental health services in rural Missouri.

Witnesses discussed the need for greater care coordination for Medicaid recipients and the benefits of giving recipients a stake in their health care. The working group heard testimony on the continued need for Medicaid benefits for blind individuals and the numerous problems that would occur if blind individuals were to lose the Medicaid services they currently receive.

Witnesses expressed concerns with the reorganization of the Family Services Division within the Department of Social Services. Witnesses testified to the lack of details in the planning of the reorganization, including that the current plan assumes efficiencies that are not likely to occur. Witnesses also testified that the computerized enrollment process will discourage individuals from applying for benefits they need and will cause many individuals and children to fall through the cracks.

The working group heard testimony on the need for expansion of Medicaid coverage to provide health care for the working poor in Missouri. Witness spoke to a drastic increase in patients receiving care in hospital emergency departments. Witnesses testified that emergency department care is not cost effective and greater access to primary care providers could decrease the number of people inappropriately using emergency department services.

The working group also heard testimony from the Department of Social Services, who testified for informational purposes only. Information provided by the department is attached in Appendix 1(b).

III. July 27, 2013 Hearing

At the July 27 hearing in Columbia, the working group heard testimony on current Missouri Medicaid initiatives utilized by MO HealthNet and examples of other state innovations.

Witnesses spoke to the need for expansion of Medicaid in Missouri to provide health care to Missouri's farmers and their families who currently do not have access to affordable health care. Witnesses discussed the economic benefits of expanding Medicaid coverage and the need for more primary care providers in rural Missouri.

The working group heard testimony on the need to reform MO HealthNet as part of expansion, including adding greater access to dental services, providing physical therapy services, and creating strong incentives to use primary care instead of emergency departments for non-emergent issues. Witnesses spoke to the low reimbursement rate MO HealthNet pays primary care providers and the limited drug formulary provided by MO HealthNet. Witnesses also discussed the need to support persons with disabilities to live independently and to provide services that allow for independent living.

Witnesses discussed the role of rural hospitals as both health care providers and major employers in rural Missouri. Witnesses spoke to the negative economic impact of new regulations on rural hospitals and the need for more rural health clinic and primary care providers. Witnesses expressed concerns with privatizing Medicaid services and the need for oversight if services are privatized. Witnesses also spoke to the benefits of providing behavioral health services in a health care home setting and the need for these programs to be continued and expanded.

Witnesses spoke to federal regulations and procedures, including a cap on the number of graduate medical educations opportunities, which prevent more medical students from becoming primary care physicians and the need for greater support at a state and local level to encourage medical students to choose a career in primary care. Witnesses testified that student loan debt, lifestyle preferences, and income limitations are reasons why medical students are not choosing to become primary care physicians.

Witnesses testified that expanding Medicaid would pump more tax payer money into a broken system and expansion is not in Missouri's best interest. Witnesses discussed the need for more free market solutions rather than expanding

government insurance. Witnesses spoke to the current financial state of the federal government and the need to lower the federal debt, which will not occur if Medicaid is expanded.

The working group also heard testimony from the Department of Social Services, who testified for informational purposes only. Information provided by the department is attached in Appendix 1(c).

IV. July 31, 2013 Hearing

At the July 31 hearing in Kennett, the working group heard testimony on cost sharing in MO HealthNet.

The working group heard testimony on the need to expand MO HealthNet to provide access to health care to more Missourians. Witnesses discussed the loss of disproportionate share hospital (DSH) payments that will occur regardless of whether Missouri expands Medicaid and probable loss of jobs and closure of rural hospitals if expansion does not occur. Witnesses testified that southeast Missouri is very poor and would greatly benefit from the expansion of Medicaid. Witnesses also testified that expansion would create a bridge to health care for the working poor who currently cannot afford health care and do not have access to primary care services.

Witnesses spoke to the need for reform in the MO HealthNet program, including expanding and mandating primary care services, teaching children how to maintain a healthy lifestyle, and increasing reimbursement for senior services. Witnesses also testified to the unaffordability of the current spenddown program and the need to either overhaul spenddown amounts or do away with the program altogether. Witnesses testified that spenddown is too expensive and encourages married couples to divorce to make spenddown more affordable. Witnesses discussed changing MO HealthNet reimbursement to cover chiropractic care to help alleviate the shortage of primary care providers. Witnesses also discussed the need for home health services, assisted living services, and skilled nursing services to all be considered the same level of service under MO HealthNet and for these services to be provided based on what the recipient actually needs rather than the recipient's income.

The working group heard testimony that expansion of Medicaid is not affordable for Missouri tax payers and will only create more government subsidized jobs. Witnesses testified that Missourians overwhelmingly voted in favor of Proposition C to prevent the creation of exchanges in Missouri and this shows that a majority of Missourians are not in favor of expansion. Witnesses discussed alternatives to Medicaid expansion, including free market based solutions that are incentive driven and are provided through private entities.

The working group also heard testimony from the Department of Social Services, who testified for informational purposes only. Information provided by the department is attached in Appendix 1(d).

V. *August 7, 2013 Hearing*

At the July 16 hearing in Cameron, the working group heard testimony on financing and administration of the MO HealthNet program.

Witnesses discussed the need for improved and expanded mental health services in Missouri, including prevention and early detection of mental illness. Current funding shortages mean there is no longer the ability to provide significant prevention services, rather current services are crisis-oriented and are simply used as triage. Witnesses spoke to the need for expansion to allow for early detection and prevention for individuals in the expanded population. Witnesses also testified that expanding mental health funding and expanding programs, such as the Disease Management 3700 Project (DM 3700), would help get individuals with mental illness out of local jails and state prisons and into facilities that can actually treat their illnesses.

Witnesses discussed expanding Medicaid to ensure better access to care, which would then lead to healthier Missourians and, as a result, would allow for a more productive citizenry. Witness spoke to the lack of access to care in rural Missouri and the ability of Medicaid expansion to provide incentives for providers to practice in rural areas. Witnesses testified that expansion of Medicaid is a moral imperative and could drastically reduce instances of homelessness. Witnesses also testified that the current Medicaid system is not perfect, but it is a good start and reform could occur simultaneous with expansion.

Witnesses spoke to the need for Medicaid reform, including more support for independent living programs and more coordination of care, especially for individuals with complex and chronic conditions. Witnesses discussed the need to seek alternatives to managed care models because managed care makes it harder for providers to actually provide care and does not follow any set of regulations, so the companies pick and choose the regulations they will follow, to their benefit. Witnesses also discussed the importance of keeping sheltered workshops open and functioning. Witnesses discussed changing MO HealthNet reimbursement to cover chiropractic care to help alleviate the shortage of primary care providers. Witnesses also discussed the need to change the services reimbursed by MO HealthNet, including providing rehabilitation services and physical therapy after surgery. Witnesses testified to a lack of transparency in emergency department billing and the inability to estimate the cost of a visit to the emergency department.

The working group heard testimony that expansion of Medicaid would increase government regulation, which increases the cost of health care. Witnesses testified that the role of government in health care should be minimized and instead encourage competition using a free market model. Witnesses spoke to a need for less regulation to end market concentration and allow for smaller clinics to thrive. Smaller clinics can easily react to changes in medical technology, whereas larger hospital conglomerates cannot. Witnesses testified that the role of government in health care, if there is one, is to acts as a source for consumer information, which is

lacking in the current health care system. Witnesses also testified that accepting more federal money through expansion is bad fiscal policy for Missouri and MO HealthNet eligibility should be scaled back where possible to restore Medicaid to a true safety net program.

The working group also heard testimony from the Department of Social Services, who testified for informational purposes only. Information provided by the department is attached in Appendix 1(e).

VI. August 14, 2013 Hearing

At the July 16 hearing in St. Louis, the working group heard testimony on general Medicaid issues.

Witnesses testified that Medicaid expansion would allow coverage of those individuals who are male or disabled with low incomes and would also allow these individuals to receive primary care outside of emergency departments and would provide coverage for much needed yearly physical exams. Witnesses discussed the need for Medicaid expansion to eliminate the requirement of a disability determination for many individuals with mental illness before they can receive MO HealthNet benefits. Witnesses testified that everything we purchase includes the cost of providing health care for that company's employees, thus the cost of health care in inherent in every transaction. By expanding Medicaid, some of that cost could be reduced.

Witnesses spoke to the need for Medicaid reform, including providing coverage for home health services for those who have had a catastrophic event and need services to continue after being discharged from the hospital, such as wound care, transitional care, and outpatient physical therapy. Witnesses discussed reform that provides continuity of care for Medicaid recipients upon release from incarceration. Upon incarceration, individuals lose all benefits and must reapply for all lost benefits once they are released. This causes a lapse in care because individuals who are incarcerated have a constitutional right to health care while incarcerated but lose that right upon release. Witnesses testified that expansion and reform should occur simultaneously because the Medicaid system needs to be fixed; however, people die without access to health care.

Witnesses discussed the benefits of care coordination, particularly for individuals who suffer from chronic disease; however, care coordination could benefit all individuals enrolled in MO HealthNet. Care coordination improves patient compliance and health outcomes for individuals with chronic diseases and achieves savings by avoiding costly emergency department visits, expensive complications, and hospital visits. Witnesses spoke to the lack of access to primary care in Missouri and recommended that reduced regulation of advanced practice registered nurses (APRNs) would allow APRNs to practice to the full extent of their training and would help alleviate the primary care provider shortage in Missouri.

The working group heard testimony that Medicaid is a broken system and should not be expanded until the entire system is fixed and functional. Witnesses testified that part of the problem with Medicaid is the vast amount of waste, fraud, and

abuse that makes an already expensive program even more costly to tax payers. Witnesses spoke to the inability of the Department of Social Services to confirm that a majority of benefit recipients meet eligibility criteria. Witnesses discussed the need for the department to be held accountable for their failures and asked for an overhaul of the department before even considering adding more individuals to the MO HealthNet program. Witnesses spoke to the department's failure to be good stewards of tax payer dollars and as a result believe the department should not receive any more tax payer money until they can address all of their shortfalls.

Conclusion

The working group heard testimony from many Missourians during its six hearings held in Independence, Springfield, Columbia, Kennett, Cameron, and St. Louis. The testimony given to the working group was heavily weighted in favor of increasing Medicaid eligibility in Missouri while simultaneously reforming the MO HealthNet program to address its shortcomings.

Appendix 1: Information Provided by the Department of Social Services

Appendix 1(a): MO HealthNet: Missouri's Medicaid Program

MO HealthNet: Missouri's Medicaid Program

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

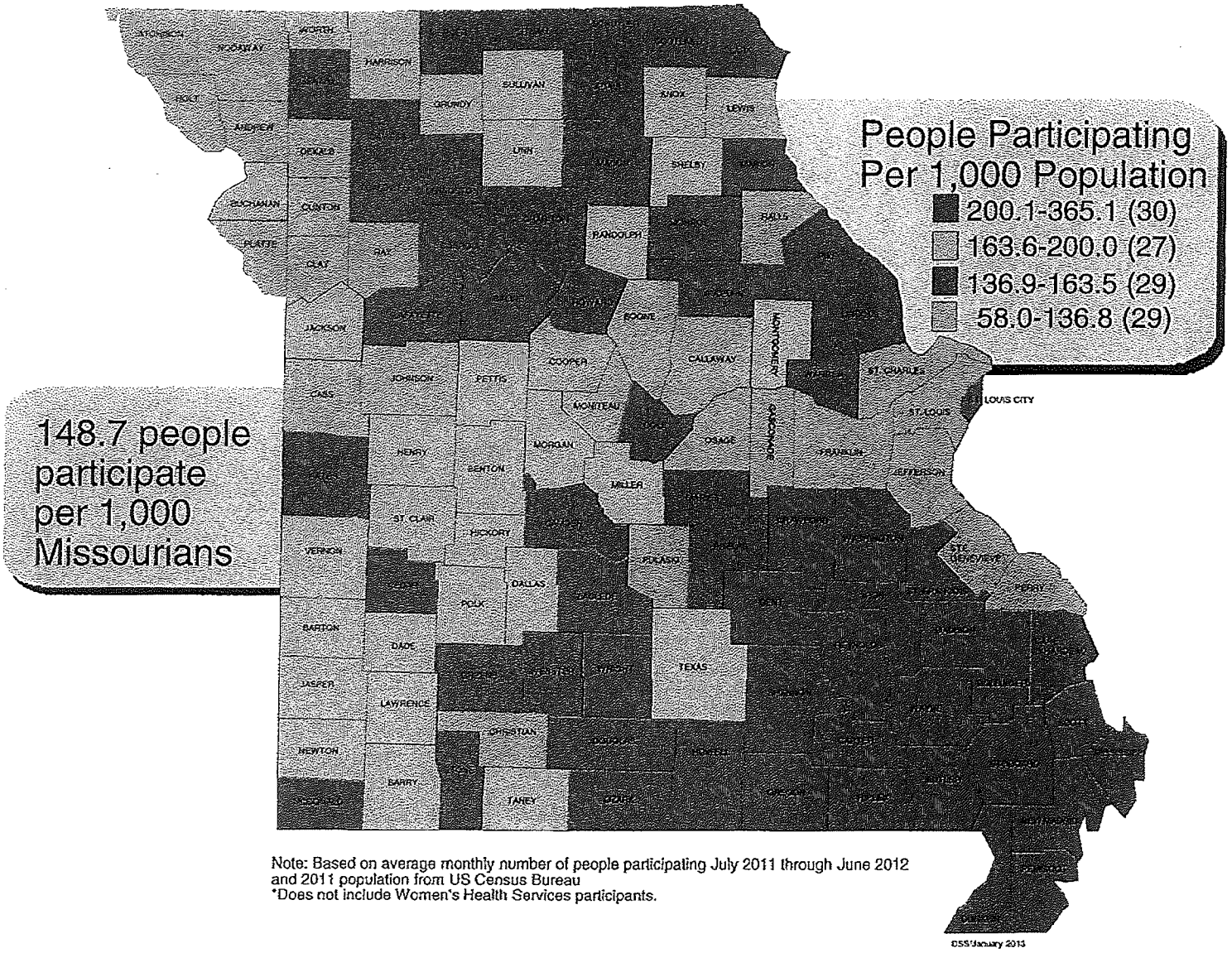
July 10, 2013

MoHealth Net

- **OUR EMPHASIS is to increase the health status of Missourians through better:**
  - **Coverage for health care services**
  - **Access to those services**
  - **Quality of those services**
  - **Accountability to taxpayers**

2012 Average Monthly MO HealthNet Participation Per 1000 Population

(893,976* Enrollees)



Note: Based on average monthly number of people participating July 2011 through June 2012 and 2011 population from US Census Bureau

*Does not include Women's Health Services participants.

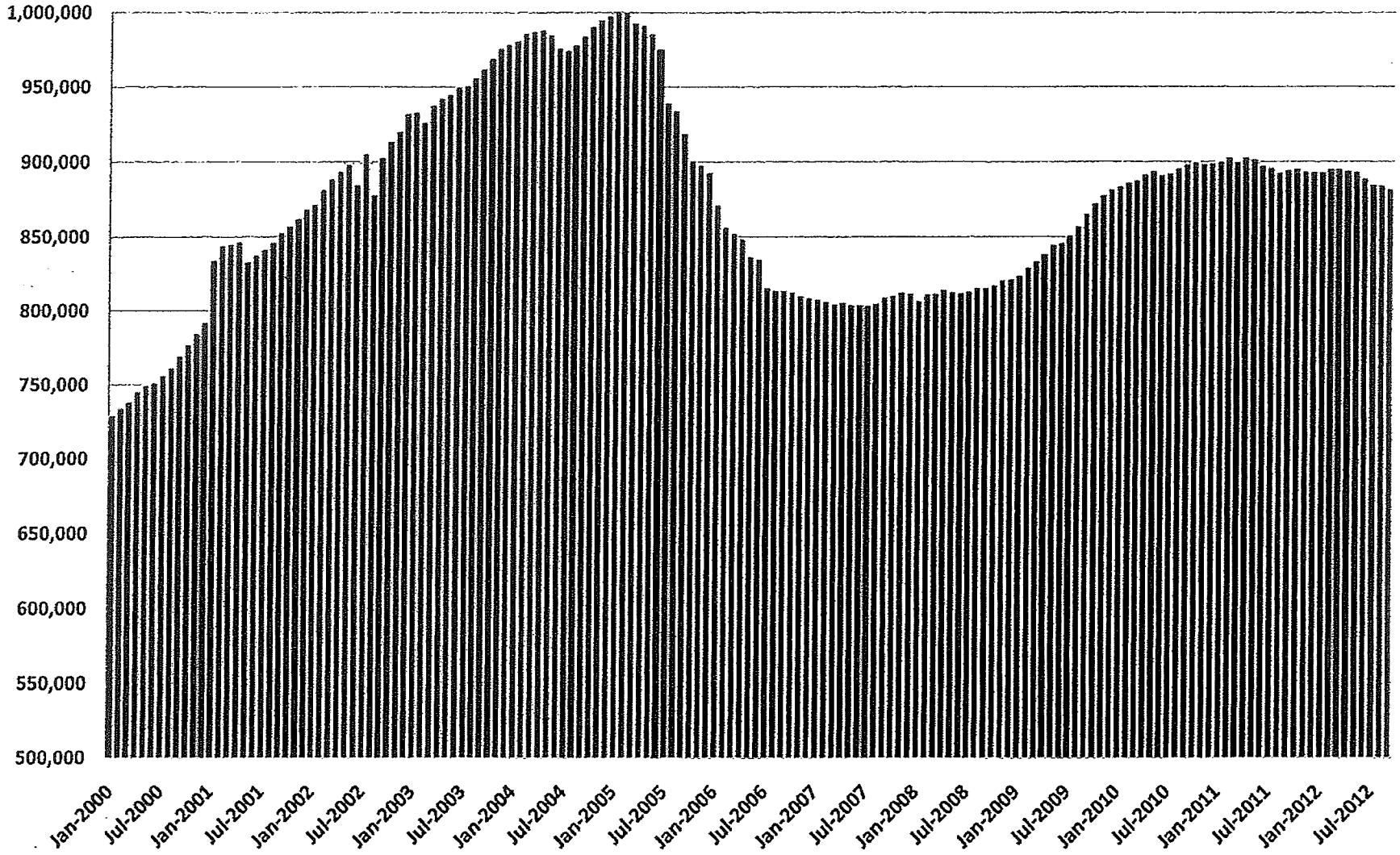
Missouri Medicaid: 873,466 Enrolled

- 532,100 children
- 27,240 pregnant women
- 77,289 low income parents
- 161,491 persons with disabilities
- 75,346 low income elderly

As of 5.31.13

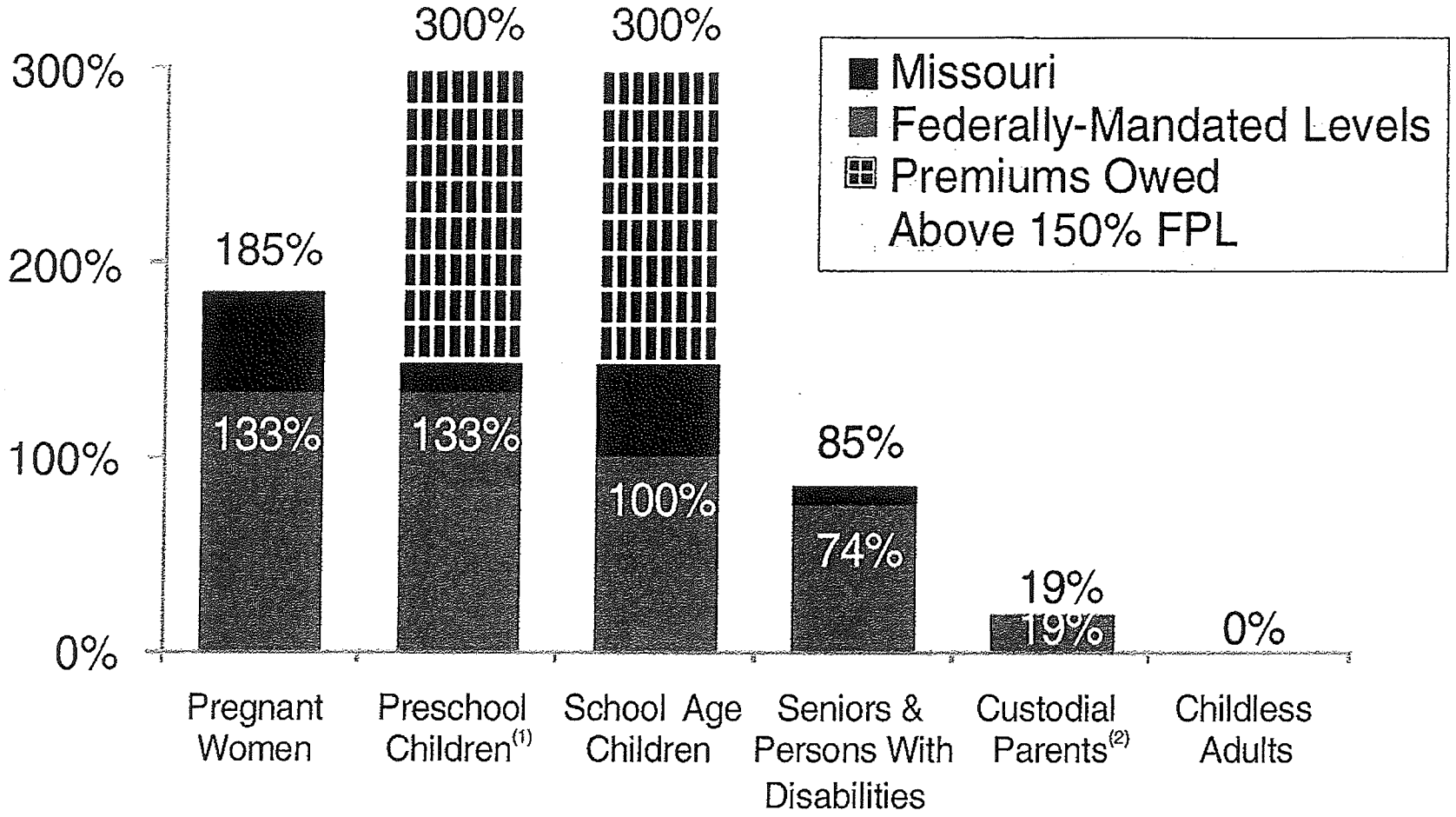
MO HealthNet Enrollment

Enrollment as of the End of the Month, January 2000 to July 2012



Does not include women enrolled in the Women's Health Services category

MO HealthNet Coverage Compared to Federally-Mandated Eligibility Levels (%FPL)



(1) Premiums required for children less than one year of age beginning at 185% FPL
(2) TANF level is required

2013 ANNUAL INCOME RATES
Percent of Federal Poverty Level

Family Size	19% Annual Amount	85% Annual Amount	100% Annual Amount	138% Annual Amount	185% Annual Amount	300% Annual Amount
1	$2,183	$9,767	$11,490	$14,856	$21,257	$34,470
2	$2,947	$13,184	$15,510	$20,123	$28,694	$46,530
3	$3,711	$16,601	$19,530	$25,390	$36,131	$58,590
4	$4,475	$20,018	$23,550	$30,657	$43,568	$70,650
5	$5,238	$23,435	$27,570	$35,923	$51,005	$82,710
6	$6,002	$26,852	$31,590	$43,594	$58,442	$94,770

Medicaid Benefits - Mandatory

- Physician, Nurse Practitioner, and Nurse Midwife Services
- Hospital Services – Inpatient and Outpatient
- Laboratory and Radiology Services
- Family Planning Services and Supplies
- Nonemergency Medical Transportation
- Federally-qualified Health Centers and Rural Health Clinics
- Comprehensive Access to Services for Children (EPSDT)

Medicaid Benefits - Optional

Covered in Missouri

- ❑ Prescription Drugs
- ❑ Eyeglasses, Prosthetic Devices
- ❑ Case Management Services for Specific Conditions

Not Covered in Missouri

- ❑ Chiropractic Services
- ❑ Adult Dental Services
- ❑ Adult Physical/Occupational/Speech Therapy
- ❑ Acupuncture

MO HEALTHNET EXPENDITURES BY LARGE ELIGIBILITY GROUPS
FISCAL YEAR 2012

Expenditures (In Millions)	Elderly	Persons with Disabilities (Title XIX and State Only)	Children (Traditional Title XIX and State Only)	Children's Health Insurance Program (CHIP)	Custodial Parents (Adults)	Pregnant Women	Total	Women's Health Services
Fed/state match rate	Title XIX 63 / 37	Title XIX 63 / 37	Title XIX 63 / 37	Title XXI 74 / 26	Title XIX 63 / 37	Title XIX 63 / 37		1115 Waiver 90 / 10 ##
Nursing Facilities	$657.0	$273.4	$0.0	$0.0	$0.2	$0.0	$930.6	$0.0
Hospitals	$52.2	$794.2	$228.7	$17.7	$82.5	$59.9	$1,235.2	$0.2
Dental	$1.6	$4.3	$8.5	$1.7	$0.3	$0.9	$17.3	$0.0
Pharmacy	$29.0	$644.4	$268.4	$51.0	$95.0	$16.8	$1,104.6	$1.6
Physician Related	$48.2	$301.5	$91.8	$12.8	$39.2	$42.3	$535.8	$8.2
In-Home	$216.4	$336.7	$0.4	$0.0	$1.8	$0.2	$555.5	$0.0
Rehab & Specialty	$86.0	$110.3	$13.1	$1.9	$3.8	$1.2	$216.3	$0.0
Buy-In	$84.7	$93.8	$0.0	$0.0	$0.2	$0.0	$178.7	$0.0
Mental Health	$33.4	$684.4	$89.1	$8.5	$13.4	$2.9	$831.7	$0.0
State Institutions	$10.1	$114.3	$92.8	$1.0	$0.1	$0.0	$218.3	$0.0
EPSDT	$0.0	$40.7	$99.5	$9.8	$0.5	$1.4	$151.9	$0.0
Managed Care	$0.0	$0.0	$689.3	$76.1	$203.1	$60.4	$1,028.9	$0.0
Total (In millions)	$1,218.6	$3,398.0	$1,581.6	$180.5	$440.1	$186.0	$7,004.8	$10.0

	Elderly	Persons with Disabilities (Title XIX and State Only)	Children (Traditional Title XIX and State Only)	Children's Health Insurance Program (CHIP)	Custodial Parents (Adults)	Pregnant Women	Total	Women's Health Services
Number of Enrollees	77,460	167,367	470,490	70,336	80,430	27,895	893,978	63,600
Annual Cost Per Person	$15,732	$20,303	$3,362	$2,567	$5,471	$6,667	$7,836	$158
Monthly Cost Per Person	$1,311	$1,692	$280	$214	$456	$556	$653	$13
Monthly State Cost Per Person	$485	$635	$105	$56	$169	$206	#	*$1.32*

(Source: Annual Table 23 for SFY-12)

Elderly includes Old Age Assistance and Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB).

Persons with Disabilities include Permanently & Totally Disabled, Aid to the Blind, Blind Pension, and Ticket to Work Health Assurance Program (TWHAP).

Children Traditional Title XIX and State Only includes MO HealthNet for Children, MO HealthNet for Families - Child, Foster Care, Child Welfare Services, DYS - General Revenue, Title XIX - Homeless, Dependent, Neglected (HDN), Children in a Vendor Institution, Missouri Children with Develop Disabilities (MOCDD), Presumptive Eligibility for Children and Voluntary Placement.

Children's Health Insurance Program (CHIP) includes No Cost and Premium enrollees.

Custodial Parents (Adults) include MO HealthNet for Families - Adult, Refugees, Women with Breast or Cervical Cancer and Independent Foster Care.

Pregnant Women includes MO HealthNet for Pregnant Women (Poverty and MAF Income) and Presumptive Eligibility for Pregnant Women.

State Monthly Cost per Person and Federal/State match rate vary by category of eligibility.

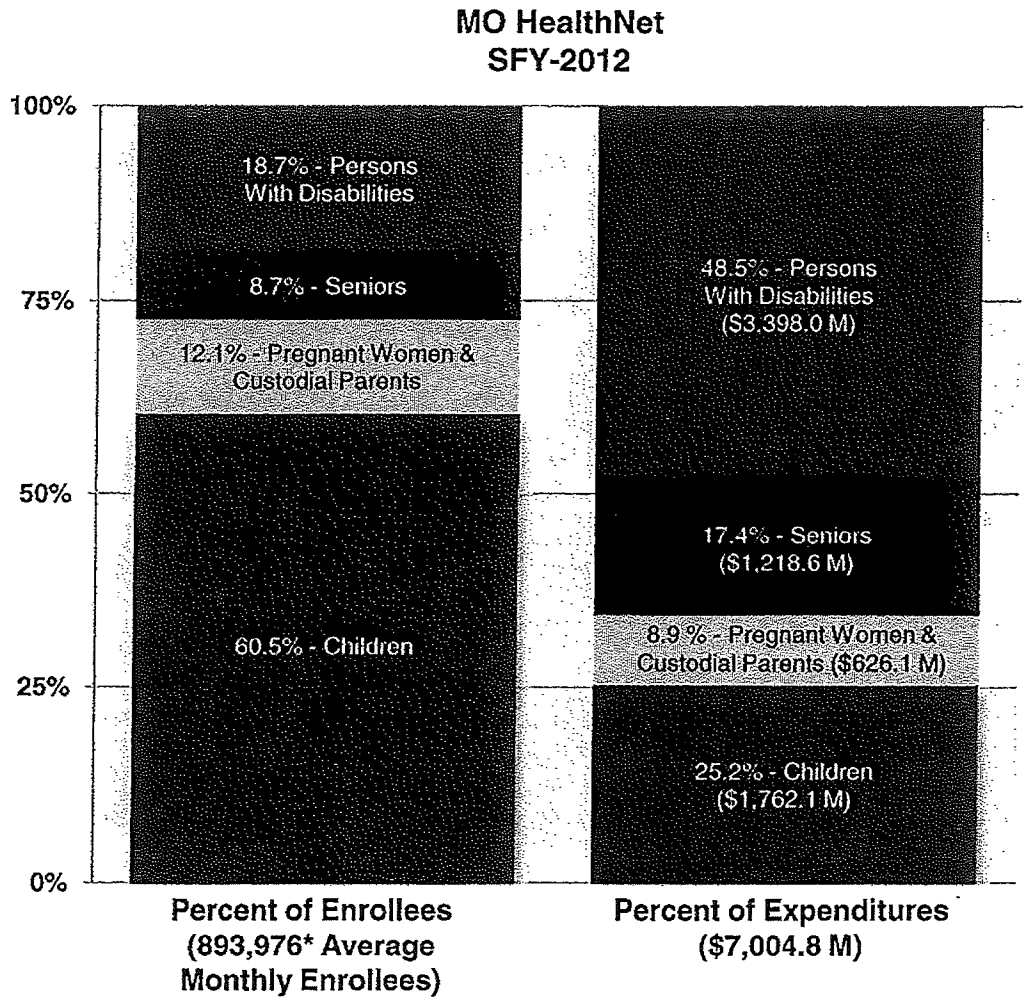
MO HealthNet Enrollees and Expenditures

In SFY-2012, seniors and persons with disabilities comprised more than 27% of enrollees, however, they accounted for nearly 66% of MO HealthNet expenditures.

Number of People SFY-2012

(Average Monthly)

Persons With Disabilities	167,367
Seniors	77,460
Pregnant Women & Custodial Parents	108,325
Children	540,824
Total	893,976



*Data reflects Department of Social Services, Table 23, Medical Statistics excluding Women's Health Services

Persons with Disabilities include Permanently and Totally Disabled; Aid to the Blind; Blind Pension; Specified Low-Income Medicare Beneficiary; and, Ticket to Work Health Assurance Program (TWHAP)

Seniors include Old Age Assistance; Qualified Medicare Beneficiary (QMB) and, Specified Low-Income Medicare Beneficiaries (SLMB)

Pregnant Women & Custodial Parents include MO HealthNet for Families-Adult; Refugee; Women with Breast or Cervical Cancer; Independent Foster Care Children Ages 18-21; MO HealthNet for Pregnant Women (Poverty and Income); and, Presumptive Eligibility (Pregnant Women)

Children includes MO HealthNet for Children; SCHIP (including no cost and premium enrollees); MO HealthNet for Families-Child; Foster Care; Child Welfare Services; Title XIX-Homeless, Dependent, Neglected (HDN); DYS-General Revenue; Children in a Vendor Institution; Missouri Children with Developmental Disabilities (MOCDD); Presumptive Eligibility for Children; and, Voluntary Placements

Fee for Service (FFS) Model

35-40% of medicaid population uses this

How do Participants Access Services?

- May Choose Any Willing Enrolled Provider

Which Participants Access Services by FFS?

- Seniors
- Persons with Disabilities
- Children outside Managed Care Counties
- Low Income Parents outside Managed Care Counties

How are Providers Reimbursed?

- Providers File Claims and are Paid Directly by MHD

Managed Care Model

Payer (state)
Contracts w/ health plans for coverage
- children / low income parents
Esp. w/ KC/STL

How do Participants Access Services?

- Enroll with One of Three Contracted Health Plans

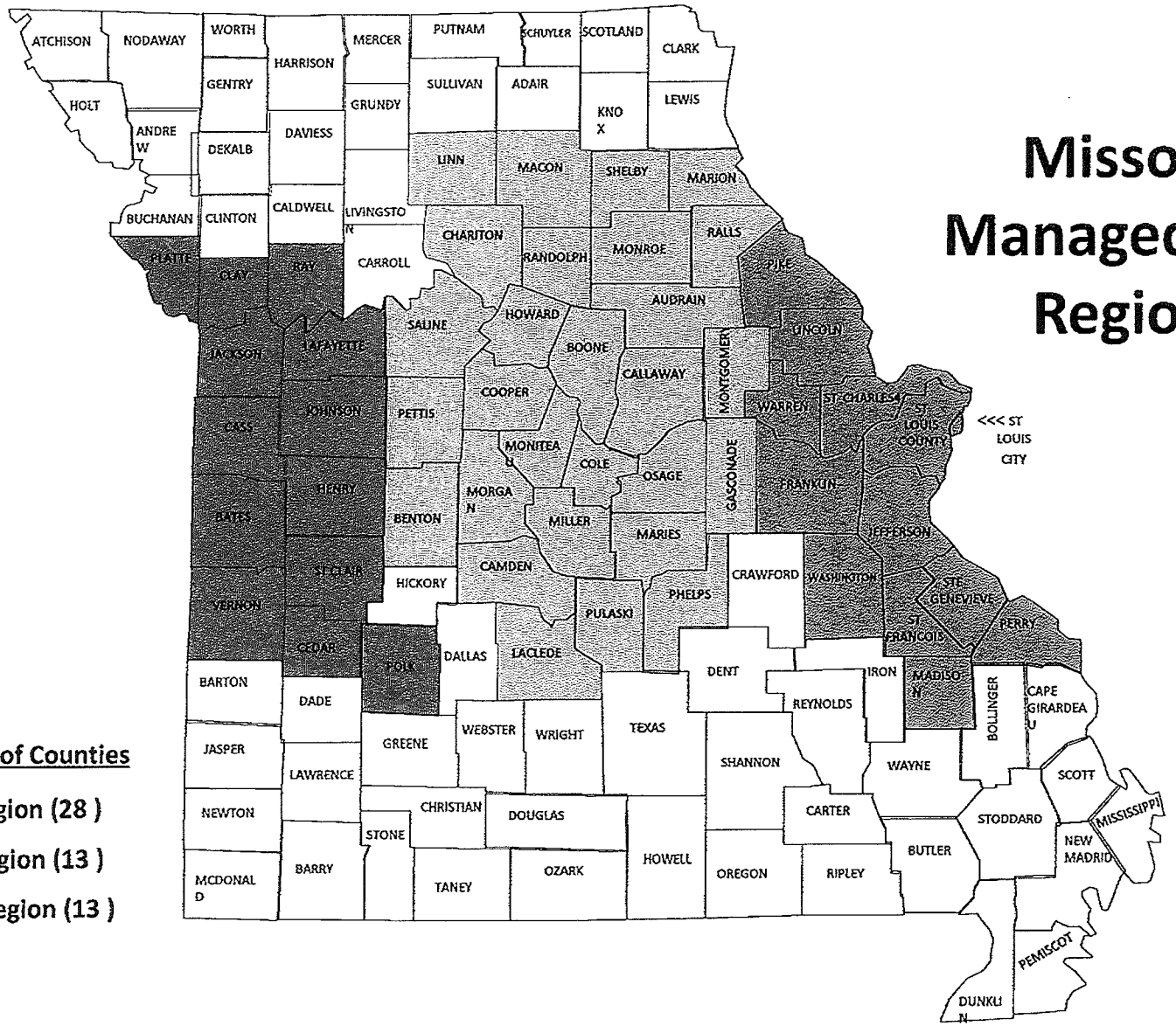
Which Participants Access Services by FFS?

- Children in Managed Care Counties
- Low Income Parents in Managed Care Counties

How are Providers Reimbursed?

- Health Plans are Paid a Monthly Contracted Payment for Each Covered Life by MHD. Health Plans are Billed Directly by Providers and Pay Claims

Missouri Managed Care Regions



Number of Counties

Central Region (28)

Eastern Region (13)

Western Region (13)

MO HealthNet Program Management: A Record of Innovation

- Focus on the High Need, High Cost Populations
- Promotion of Primary Care Access
- Coordination of Behavioral and Physical Care
- Leverage Health Information Technology
- Leading Edge Pharmacy Program Management
- Maximize Provider Taxes, Federal Funding
- Ongoing Efficiency Adjustments
- Active Surveillance for Fraud and Abuse

Focus Across Departments – DSS, DMH, DHSS

- Patient-centered Health Homes
- Coordination of Behavioral and Physical Care
- Define, Measure, Improve Upon Quality of Care
- Better Understand High Need Populations
  - Permanently and Totally Disabled
  - Low Income Elderly
  - Seriously Mentally Ill

MoHealth Net

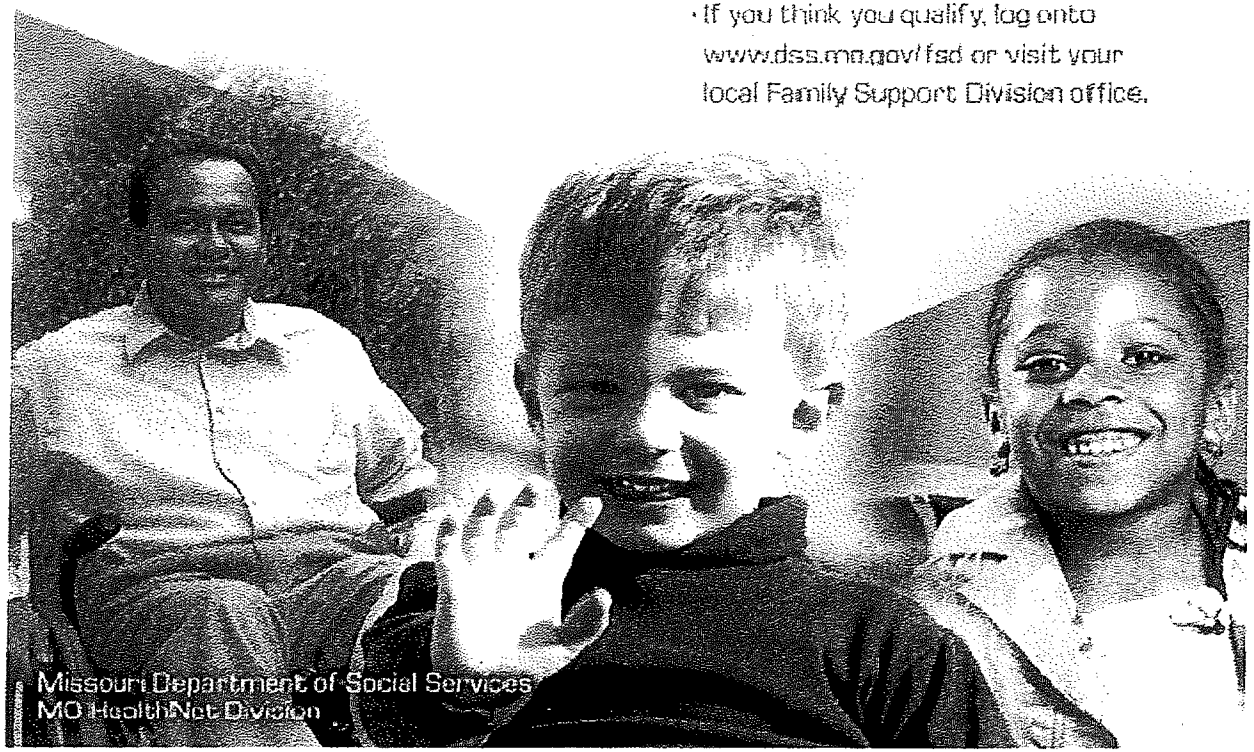
A Better Approach To Health Care

You can expect:

- Better access to quality care
- Active involvement in your health care
- Improved health care through technology
- Better health outcomes

Benefits:

- Prevention, health and wellness
- Coordinated care and treatment
- Choice of health care home/provider
- Personalized health plan
- Care based on proven practices
- If you think you qualify, log onto www.dss.mo.gov/fsd or visit your local Family Support Division office.



Thank you

Appendix 1(b): MO HealthNet: Eligibility

MO HealthNet: Eligibility

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

July 16, 2013

Current Medicaid Application Process

- **How to Apply**
  - Call to request application at 1-855-373-4636
  - Go to any local Family Support Division Office
  - Apply on line (children's coverage only) http://dss.mo.gov/mhk/

- **All applicants must have verifiable evidence of:**
  - Missouri residency
    - Driver's license, utility bill
  - US Citizen or Eligible Qualified Non-Citizen
    - Birth certificate and ID, US Citizen ID card, US passport
  - Social Security Number
    - Social Security Card

Current Medicaid Application Process

- **Income**
  - Parents, Pregnant Women and Children
    - Income of the applicant (custodial parent(s) for children's coverage; parents of unborn child if living together)
      - Earned Income Disregards
    - Unearned income (e.g. SSI/SSA benefits, VA benefits, child support, pensions)
  - Elders and disabled
    - Income of the applicant and his/her spouse
    - Unearned income (e.g. SSI/SSA benefits, VA benefits, pensions)
- **Assets (Resources)**
  - Parents, Pregnant Women and Children
    - No asset tests, except for S-CHIP
  - Elders and disabled
    - Cash, financial investments, real and personal property must be reported
      - Exclusions
        - House and adjoining land
        - One Car
        - Prepaid burial plans

2013 Annual Income Rates
Percent of Federal Poverty Level

Family Size	18% Annual Amount	85% Annual Amount	100% Annual Amount	138% Annual Amount	185% Annual Amount	300% Annual Amount
1	$2,183	$9,767	$11,490	$15,856	$21,257	$34,470
2	$2,947	$13,184	$15,510	$21,404	$28,694	$46,530
3	$3,711	$16,601	$19,530	$26,951	$36,131	$58,590
4	$4,475	$20,018	$23,550	$32,499	$43,568	$70,650
5	$5,238	$23,435	$27,570	$38,047	$51,005	$82,710
6	$6,002	$26,852	$31,590	$43,594	$58,442	$94,770

Medicaid Eligibility Determinations and Review

When a participant's circumstances change

- All participants are required to report any changes within 10 days
- FSD utilizes data matches to identify any changes not otherwise reported
- FSD acts on all changes identified to re-determine eligibility
- Eligibility ends on the day FSD determines the participant is no longer eligible (or the last day of the current eligibility month)

Reinvestigations

- All cases are reviewed at least annually
- All eligibility factors are reviewed and necessary verification is obtained

Ex Parte Review

- When a participant becomes ineligible in one category federal law requires that the state explore eligibility under other categories

Due Process

- Participants may appeal FSD eligibility determinations to a DSS hearing officer and then to circuit court

Current MO HealthNet Programs

Medicaid Programs for Children

MO HealthNet for Kids

- Provides full Medicaid benefit
- Under age 19
- Net family income up to:
  - 185% FPL for children under age 1
  - 133% FPL for children ages 1-5
  - 100% FPL for children ages 6-18
- Parent must cooperate in obtaining medical support order
- Certain providers can establish "presumptive eligibility" so services can begin immediately
  - Application must be made within 30 days and the pregnant woman must be found eligible for coverage to continue

Annual enrollment

Medicaid Programs for Children

S-CHIP

- Provides full Medicaid benefit except transportation
- Under age 19
- Income below 300% FPL
- Must be uninsured
  - S-CHIP children must be uninsured unless premium paid by HIPP
  - Premium group children must be uninsured 6 months
  - Child that has reached coverage limits does not have to wait
- Cannot have access to affordable health insurance - Premium group
  - $73 to $183 per month depending on family income per family
- Assets less than $250,000 - Premium group
- Must pay a monthly premium(family)
  - 150% - 185% - $27 premium*
  - 185% - 225% - $90 premium*
  - 225% - 300% - $221 premium*

  **Family of 4*
- Parent must cooperate in obtaining medical support order

Medicaid Programs for Parents and Children

MO HealthNet for Families

- Provides full Medicaid benefit
- Both custodial parent and child(ren) under age 19 are covered
- Income cannot exceed the July 16, 1996 AFDC income limits
  - Family of 2 – net monthly income less than $234
  - Family of 3 – net monthly income less than $292
  - Family of 4 – net monthly income less than $342
  - Missouri's standards are at the federal minimums
- Parent must cooperate in obtaining medical support order
- 12 Month Transitional Benefit
  - If the family's income increases and the parent/child would no longer be eligible, coverage continues for 12 months (federal requirement)
  - If net income exceeds 185% FPL, coverage ends

Medicaid Programs for Women

MO HealthNet for Pregnant Women

- Provides full Medicaid benefit
- Net family income does not exceed 185% FPL for household size, including the unborn child
- Pregnancy must be verified
- Coverage is provided throughout the pregnancy plus 2 months postpartum
- Certain providers can establish "presumptive eligibility" so services can begin immediately
  - Application must be made within 30 days and the pregnant woman must be found eligible for coverage to continue

Medicaid Programs for Women

Uninsured Women's Health Services

- Provides a very limited benefit package
  - Family planning treatments and services
  - Testing/treatment of sexually transmitted diseases
  - Other health care services (acute medical, hospitalization, etc.) are not provided to this group
- Women age 18 through 55
- Net family income does not exceed 185% FPL
- Uninsured or has insurance or access to employer-sponsored insurance that does not cover family planning services
- Assets do not exceed $250,000

Medicaid Programs for Women

Breast and Cervical Cancer Coverage

- Provides full Medicaid benefit
- Women under age 65 who are in need of treatment for breast or cervical cancer
- Uninsured or has health insurance that does not cover breast or cervical cancer treatment
- Not eligible for coverage under any other MO HealthNet program
- Screened for breast or cervical cancer by Missouri's Show Me Healthy Women Program or by a MO HealthNet provider

Medicaid Programs for Elders and/or the Disabled

MO HealthNet for the Aged, Blind & Disabled

- Provides full Medicaid benefit
- Participants must be
  - elderly (65 and over),
  - legally blind; or
  - determined permanently and totally disabled by SSA or DSS
- Net income limits
  - Elders & disabled: 85% FPL
  - Blind: 100% FPL
- Asset limits
  - Elders & disabled: $1,000 (individual) or $2,000 (couple)
  - Blind: $2,000 (individual) or $4,000 (couple)
- Spenddown
  - Elders and disabled persons who exceed income limits can be made eligible after incurring health care costs in the amount of the excess income

Medicaid Programs for Elders and/or the Disabled

Medicare Premium Assistance

- Qualified Low Income Medicare Beneficiary (QMB)
  - Income limit: 100% FPL
  - Asset limit: $7,080 (individual) or $10,620 (couple)
  - Must be enrolled in Medicare Part A
  - Pays Medicare Part B (and in some cases Part A) premiums, copayments and deductibles
- Special Low Income Medicare Beneficiary (SLMB)
  - Income limit: 120% FPL
  - Asset limit: $7,080 (individual) or $10,620 (couple)
  - Must be enrolled in Medicare Part A
  - Pays Medicare Part B
- Qualifying Individual
  - Income limit: 135% FPL
  - Asset limit: $7,080 (individual) or $10,620 (couple)
  - Must be enrolled in Medicare Part A
  - Pays Medicare Part B

Medicaid Programs for Elders and/or the Disabled

Sunset Aug 2019

Ticket to Work Health Assurance

- Provides full Medicaid benefit
- Age 16 through 64
- Blind or permanently and totally disabled
- Employed with Social Security and Medicare taxes withheld
- Gross income limit 300% of FPL
  - Participants with gross income over 100% of FPL must pay monthly premium
- Net income limit 85% of FPL
  - Income disregards include:
    - All earned income of the disabled worker, all SSI or the first $50 of SSDI income
    - The first $65 + 50% of the balance of a non-disabled spouse's earned income
    - A $20 standard deduction, plus deductions for health insurance premiums and for impairment-related employment expenses
- Assets less than $1,000 (individual) or $2,000 (couple)

Patient Protection and Affordable Care Act (PPACA)

Patient Protection and Affordable Care Act (PPACA)

Maintenance of Effort

- PPACA also contains "maintenance of effort" (MOE) provisions that require states to continue to fund their Medicaid and Medicaid expansion programs until the health insurance exchanges, set forth in PPACA, are established, in 2014

- The MOE for children's health insurance programs applies until 2019

- Specifically, PPACA states that "as a condition of receiving any federal payment" under a state's Medicaid plan, the state may not implement any "eligibility standards, methodologies, or procedures under the State plan...that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment" of PPACA

Patient Protection and Affordable Care Act (PPACA)

Modified Adjusted Gross Income (MAGI)

- MAGI will be the new Medicaid income standard for adults and children
- Following IRS rules, much as you follow the IRS forms when filing your tax return, a household's Modified Adjusted Gross Income (MAGI) is determined in the following manner:
  - The household's gross income is the total income minus certain exclusions (e.g. public assistance payments, employer contributions to health insurance payments)
  - From the gross income subtract allowable deductions (e.g. business deductions, losses from sale of property and alimony payments) to derive the adjusted gross income
  - To the adjusted gross income amount, add any
    - Foreign earned income excluded from taxes
    - Tax-exempt interest
    - Tax-exempt social security income
  - This amount is the calculated MAGI
- In Missouri, MAGI standards will take effect January 1, 2014 (as required by federal law) and SB 127 (2013)

Patient Protection and Affordable Care Act (PPACA)

Household Composition

- The definitions of "household" are changed by PPACA for the purpose of determining Medicaid eligibility for adults and children
- Household composition is determined by considering the individuals in the household and the tax filing status of the household members. Generally speaking, for purposes of determining Medicaid eligibility:
  - For parents who are filing a joint tax return, the income of the primary tax payer and all claimed dependents (including the children) is counted
  - For married couples who do not file together, but live together, the income of both spouses is counted
  - For families with stepparent/stepchildren, the income of the primary tax payer and all claimed dependents, including the stepparent/stepchildren, is counted
  - For a caregiver who is supporting, and claiming as a dependent, an extended family member or an unrelated individual, the income of the caregiver is not counted

Patient Protection and Affordable Care Act (PPACA)

Federal Data Hub

- The ACA creates a federal data hub that will be used for purposes of:
  - Identity verification
  - Income verification/validation
- DSS plans to use the federal hub as well as existing data sources

Interaction with Insurance Exchanges

- Missouri did not opt to establish and operate its own health insurance exchange
- The Federal government will establish and operate a health insurance exchange for Missourians to shop for and purchase health coverage
- Federal law requires state Medicaid eligibility systems and the state's insurance exchange to communicate with each other

Missouri Eligibility Determination and Enrollment System (MEDES)

Missouri Eligibility Determination and Enrollment System (MEDES)

Today's System - FAMIS

- Green-screen technology (mainframe/COBOL platform)
- Limited ability to provide online services for customers
- Manual data entry
- Inflexible – not easily modernized

Tomorrow's System - MEDES

- Web-based technology
- Customer portal providing 24/7 electronic access to customers
- Point and click technology
- Easily modified
- In development
  - EngagePoint – prime contractor awarded June 2013
  - MAGI-based eligibility standards scheduled to be operational January 1, 2014
  - MEDES anticipated completion date of December, 2015 (inclusive of all needs-based programs in FSD)

Family Support Division Reorganization

FSD Reorganization

Historical Structure

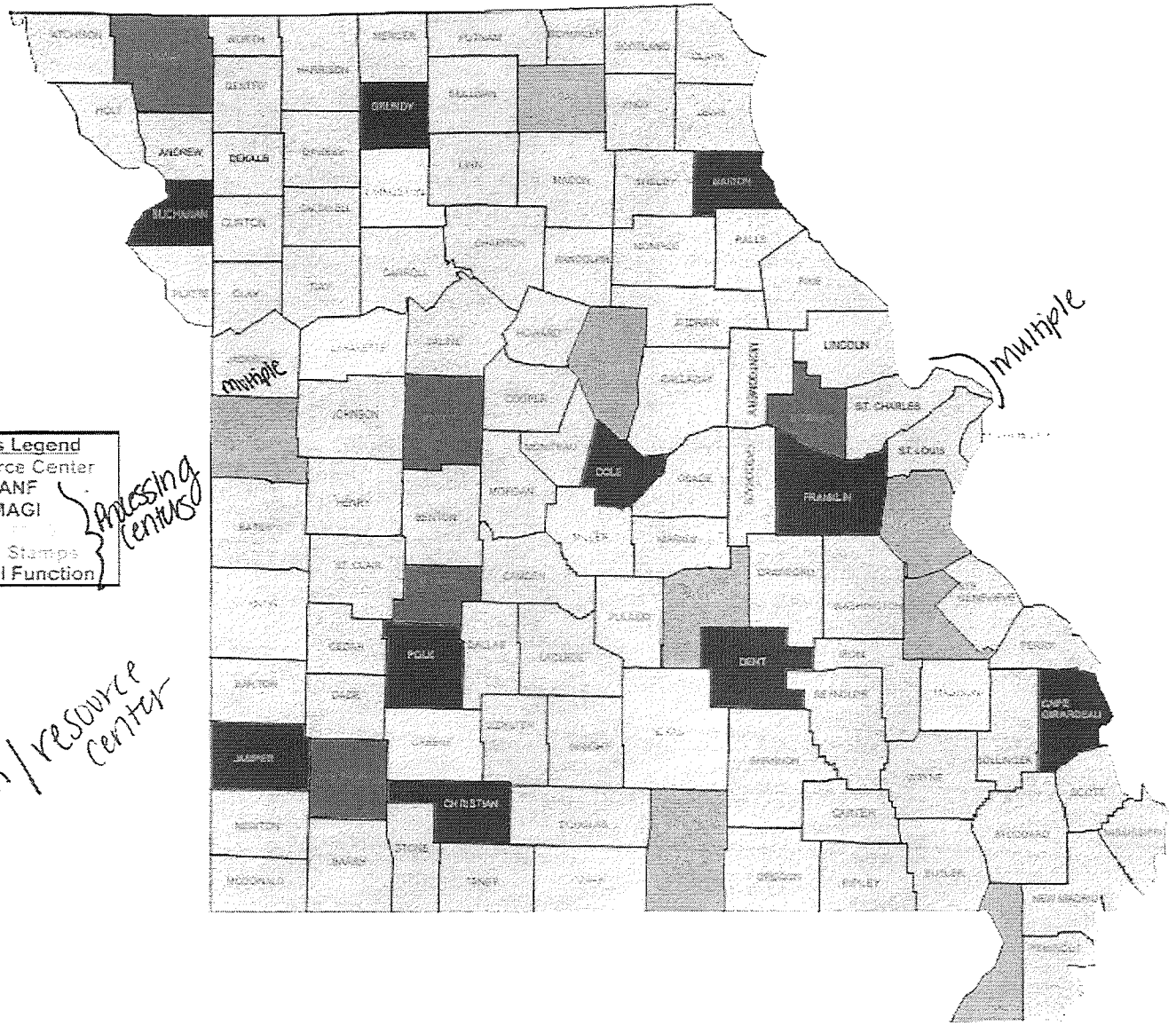
- Office in every county
- Customer must come to FSD office
- Limited accessibility
- Inefficient utilization of resources

Reorganization Structure

- Resource Center(s) in every county
- Alignment of resource centers within the communities where customers live and work
- Processing Centers for case management activities
- Improved accessibility
- Efficient utilization of resources
- Makes use of modern technology (MEDES, document imaging, etc.)
- FTE reduction of 708 over 5 years

Family Support Division

Proposed Structure



Appendix 1(c): Missouri Medicaid Initiatives and Examples of Other State Innovations

Missouri Medicaid Initiatives and Examples of Other State Innovations

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

July 27, 2013

Produced by the Missouri Department of Social Services

Presentation Outline

- **Missouri Initiatives**
  - Health Homes
  - DM 3700
  - Partnership for Hope
  - Managed Care Quality and Performance Improvement Planning

- **Other State Innovations**
  - Accountable Care Organizations – Colorado
  - Super Utilizers – Camden, New Jersey
  - Promoting Personal Responsibility – Idaho, Florida, Wisconsin, Texas
  - Payment Models – Arkansas and Oregon
  - Private Market Integration – Arkansas

Missouri Health Home Initiative

- **Missouri** was the first state to have approved state plan amendment for both **behavioral health** and a **primary care health homes.**

- **Health Homes** provide
  - Comprehensive care management
  - Health promotion
  - Comprehensive transitional care (inpatient/ED follow-up)
  - Individual and family support services
  - Referral to and coordination with community and support services

- **Behavioral health homes** are coordinated through the Community Mental Health Centers (CMHCs) and primary care health homes through the Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and other hospital-based clinics.

- Goals of **Health Homes**
  - Lower rates of emergency room use
  - Reduce in-hospital admissions and readmissions
  - Reduce healthcare costs
  - Improve health outcomes
  - Improve experience of care, quality of life and consumer satisfaction

Missouri Health Home Initiative (Cont.)

- Current populations – **Primary Care**
  - Patients with Diabetes
    - At risk for Cardiovascular Disease and a BMI > 25
  - Patients who have <u>two</u> of the following
    - COPD/Asthma
    - Cardiovascular Disease
    - BMI>25
    - Developmental Disabilities
    - Use Tobacco

- Current populations – **Behavioral Health**
  - Individuals with a serious mental illness; <u>or</u>
  - Individuals with other behavioral health problems who also have
    - Diabetes
    - COPD/Asthma
    - Cardiovascular Disease
    - BMI>25
    - Developmental Disabilities
    - Use Tobacco

Missouri Health Home Initiative (Cont.)

- Evaluation of the current model and outcomes data is ongoing.
- Preliminary data is showing estimated savings of $5 million for individuals in a **behavioral health home**.
- Indicators are that savings will be realized in the near future for individuals in the **primary care health home.**
- Reviewing **health home outcomes** and developing **recommendations** for future expansion of the health home model.
  - Right-sizing health home
  - Considerations for selection of new participants
  - Shared savings model

Missouri DM 3700 Project

- Collaborative project between the **Department of Mental Health (DMH) and MO HealthNet Division,** focusing on DMH consumers with a high spend.

- Target population
  - $20,000 minimum cost for previous 12 months or predicted to have high cost
  - A diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or recurrent major depression
  - Not a consumer of public mental health system in previous 6 months
  - Excluded nursing home, developmental disability, hospice and renal failure

- Intensive care management by CMHC teams
  - Led by project coordinator(s)
  - Team of community support staff, QMHPs, peer specialists and/or nurse liaisons
  - New outreach team or integrated with current homeless/crisis teams

- **Annual savings** for persons enrolled one year or more is approximately $4.7 million.

Missouri Partnership for Hope (PfH)

- Innovative local, state, federal partnership approach to providing **Home and Community-Based services** for Missourians with developmental disabilities.

- **PfH**, authorized under a Federal waiver, has provided services to more than 2,400 eligible individuals at an average annual cost of $8,500 per person, a 400% annual increase in new Medicaid-eligible individuals enrolling in Missouri's Development Disability (DD) waiver services over any of the prior eight years.

- For every dollar spent, the local county DD boards contribute 19 cents, the state 19 cents and the federal government 62 cents.

- Per person annual costs are capped at $12,000; however, costs are running well below that.

- **PfH** services are available in 99 counties.

- Without the in-home services offered through **PfH**, many people in the program would eventually need residential or institutional services, which are far more costly.

Missouri Managed Care Quality Improvement

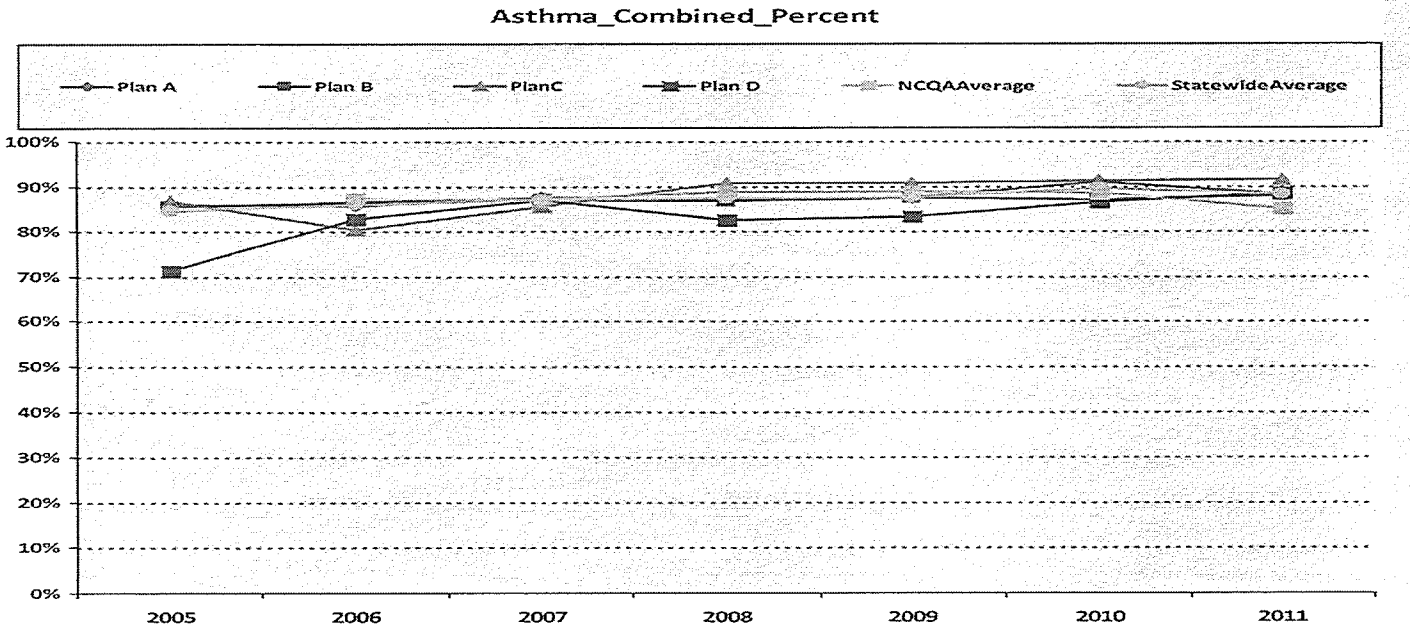
- Initial focus **on managed care population** with the following **goals**:
  - Align Managed Care and FFS measures and improve reporting, review and intervention
  - Promote Health Home concepts in managed care and FFS programs
  - Enhance care coordination and care management across managed care and FFS populations
  - Focus on population health and public health impact

- **Data tool** created to facilitate:
  - Monitoring of trends
  - Benchmarking by plan an region
  - Identification of areas of improvement
  - Development of intervention for identified areas of improvement

- Working with **managed care plans** to ensure:
  - Familiarity with population demographics, disease profiles, and levels of intensity of chronic conditions
  - Identification of sub-groups requiring more intense care coordination and management; tiering by complexity
  - Application of population health management principles
  - Emphasis on transitions of care, health promotion, individual and family supports, and community and social supports, including HCBS

Missouri Managed Care Quality Improvement (Cont.)

- Access database platform
  - Houses various measures collected annually from the health plans
    - HEDIS, Access to Care, Services Utilization, Consumer Satisfaction
  - Trend analysis across years and Comparisons between plans
  - Benchmarking against statewide and national performance



State Innovations: Accountable Care Organization

- Definition: Provider-run organization in which participating providers are collectively responsible for the care of an enrolled population, and also may share in any savings associated with improvements in the quality and efficiency of the care they provide.

- Considerations
  - Role of providers
  - Established performance metrics
  - Focus on alignment of financial incentives with policy goals
  - Balance cost containment and delivery of quality health care
  - Dual eligibles
  - Complex care (mental health services, nursing home, transportation)

- Examples
  - **Colorado:** Pilot Program implemented July 2011(completed its second year June 2013) – *more detail follows*
  - **Utah**: Model covers 70% of Utah Medicaid population (four largest counties); risked-based cap payment to ACO; ACOs have discretion over providers payment methodologies and how to share savings/penalties; ACOs may provider incentives to participants to select most appropriate, cost-appropriate care and to recognize good health decisions.
  - **Minnesota:** Three-phased implementation beginning January 2013 to implement ACOs for non duals (including those in Medicaid managed care), including behavioral health, long-term supports and other complex care needs in phase two.

Colorado ACO Pilot

- Program Goals
  - Ensure access to focal point of care or medical home
  - Coordinate medical and non-medical care
  - Improve member and provider experiences and
  - Provide the necessary data to support the goals

- Program Components
  - Seven **Regional Care Collaborative (RCCOs)** are responsible for network development; provider support; medical management and care coordination and accountability and reporting in a discrete geographic region.
  - **Primary Care Medical Providers** serve as a focal point of care or medical home for members
  - **Statewide Data and Analytics Contractor** responsible for providing actionable data at both the population and client level. Three key performance indicators: Inpatient readmissions; ER visits and high-cost imaging services.

- Program Population
  - June 2012 enrollment was **132,227 or 21% of Colorado's Medicaid population** (48,382 children and 83,845 other Medicaid eligibles)
  - Institutionalized and dually Medicare-Medicaid eligible are not actively enrolled.

Colorado ACO Pilot (Cont.)

- Payment Model
  - Initially RCCOs received $13 PMPM; beginning FY 2012-FY2013 $1 of the PMPM redirected to an incentive pool to be earned based on performance.
  - As of November 2012, RCCO base PMPM is $10.50 with adjustments by region based on contract differences.
  - PCMP paid a $4 PMPM for assigned members; beginning FY 2012-FY2013 $1 of the PMPM redirected to an incentive pool to be earned based on performance.

- Program Outcomes
  - According to November 2012 annual report, the ACC program demonstrates reduced ED use, hospital readmissions and high-cost imaging services; lower rates of aggravated chronic health condition such as asthma and diabetes;
  - Reduced cost of care for clients; full cost savings potential for ACC to be provided in November

State Innovations: Managing Super-Utilizers

- **Super-Utilizers** consume exorbitant amounts of health care services, frequenting emergency rooms and hospitals.

- In 2007, Dr. Jeffrey Brenner, MD, developed and implemented a patient care model in Camden, New Jersey to address the complex needs of super-utilizers.

- Dr. Brenner's care management model is to improve the transition of super-utilizers from the hospital to outpatient care and ensure they continue to get the medical and other services they need, empowering them to manage their own health needs so they don't end up back in the hospital.

- Program Concept
  - Database identifies **hospitalized patients with complicated medical and social needs.**
  - **A care management team** - consisting of a social worker, nurse, community health worker and health "coach"- visits the patient in the hospital, reviewing prescribed medications, conferring with doctors and nurses, and helping plan the discharge.
  - Team members visit the patient at home immediately after discharge and **provide ongoing support** for two to nine months, including connecting the patient to a primary care doctor, accompanying him or her to appointments, and helping line up needed social services.

State Innovations: Managing Super-Utilizers (Cont.)

- Data showed that hospital costs for the first 36 patients fell from a monthly average of $1.2 million to just over $500,000.

- In 2012, Rutgers, The State University of New Jersey, received an award to expand and test a **team-based care management strategy** for high-cost, high-need, low-income populations served by safety-net provider organizations in Allentown, PA, Aurora, CO, Kansas City, MO (Truman Medical Center), and San Diego, CA.

- Scaling model for larger population base (region or state versus city).

State Innovations: Personal Responsibility for Health Care Choices

- Examples of **incentives programs** implemented by states under the Deficit Reduction Act **(DRA) 2005** include Idaho and Florida.

  - **Idaho Preventative Health Assistance (PHA) Program**
    - Behavioral PHA benefits provide **vouchers** that can be used for **smoking cessation programs** including counseling and pharmacotherapy and/or **weight management services** to qualifying beneficiaries who 1) smoke or have a certain BMI defining them as overweight or underweight and who 2) have a desire to better manage their weight or to quit smoking.
    - **Preventive health assistance benefits** for children enrolled in Idaho's CHIP, allow parents who keep their children up-to-date on well-child visits and immunizations to **earn points** that can be used to **offset their premium payments**.
    - Program evaluations indicate that more children are receiving well-visits after program implementation.

  - **Florida Enhanced Benefits Reward$ Program**
    - Program allows Medicaid participants to **earn up to $125.00 credits** annually for healthy behaviors such as maintaining immunizations; dental check-ups for children; taking maintenance drugs as prescribed or joining a weight loss program.
    - **Credits** can be **spent on health-related products** (e.g., vitamins, nutritional supplements, over-the-counter medicines, baby-care items)
    - Enacted under the DRA, a 2008 program analysis by the Office of Program Policy Analysis & Program Accountability of the Florida Legislature found that many participants did not redeem credits, citing difficulty in following a cumbersome list of eligible products by brand and size. Additionally concern that lag in receiving credits (up to 90 days after the credit is earned) does not incentivize long-term changes in health behaviors.

State Innovations: Personal Responsibility for Health Care Choices

- As part of **comprehensive reform models**, states are including incentives for making good health care choices and accessing their health care benefits through the most appropriate, least expensive means.

- **Ten states** have been awarded five-year 2012 Innovation grants to test incentive programs for the prevention of chronic disease.
  - Wisconsin Model
    - Target **adult Medicaid population** with **emphasis on pregnant women.**
    - Provides cash incentives contingent upon participation in treatment and attainment of **smoking cessation goals.**
    - Participants in the control group receive treatment only, while those in the experiment group receive treatment as well as cash incentives
    - **Quit Line participants** receive a **maximum of $350 in incentives** while **First Breath** (treatment program for **pregnant women**) receive a **maximum of $595** over the course of their pregnancy plus 12 months post-partum.
  - Texas Model
    - Target **non-elderly adult Medicaid Supplemental Security Income** (SSI) and related beneficiaries **with behavioral health diagnoses** enrolled in **managed care program.**
    - Person-centered wellness planning facilitated by trained professionals who employ **Motivational Interviewing** (MI) techniques to help participants define and achieve wellness goals.
    - **$1,150/year flexible wellness account** that supports specific health goals defined by the participant.

State Innovations: Payment Models – Oregon

- Oregon's Coordinated Care Model (CCM), awarded a CMS model testing innovations grant in February, 2013, proposes to use the **state's purchasing power to realign health care payment and incentives**, so that state employees, Medicare beneficiaries, and those purchasing qualified health plans on the Exchange will have high quality, low cost health insurance options that are sustainable over time.

- Goals
  - **Integrating and coordinating** physical, behavioral, and oral health care;
  - Shifting to a **payment system that rewards quality care** outcomes rather than volume;
  - **Aligning incentives** across medical care and long-term care services and supports;
  - **Reducing health disparities** and **partnering** with community public health systems to improve health.
- Coordinate Care Organization (CCO) Role
  - A CCO is defined as **risk-bearing, community-based entities governed by a partnership** among providers of care, community members, and entities taking financial risk for the cost of health care.
  - CCOs have the **flexibility**, within model parameters, to institute their own payment and delivery reforms to achieve the best possible outcomes for their membership.
  - CCOs are **accountable** for health and care of their population and are rewarded for improving both the quality of care and health care value.
  - Over time, CCO payments will transition **from a fully-capitated model to an outcomes-based payment model**.

Approved by the Missouri
Department of Social Services

State Innovations: Payment Models – Oregon (Cont.)

- Model Implementation
  - Step 1: **Implement** its model test in Medicaid through its system of Coordinated Care Organizations (CCOs)
  - Step 2: Use the State Innovation Models Initiative funding to **expand** the new model of care to additional populations and payers, including Medicare and private plans, such as those covering state employees.

- To accelerate the transition, the Oregon Health Authority plans to create a **Transformation Center** that will disseminate best practices among CCOs and other health plans, support rapid cycle improvement, and spread the model across payers in 2014.

State Innovations: Payment Models – Arkansas

- Arkansas's Health Care Payment Improvement Initiative (a **multi-payer incentive model**) is a public, private partnership between the state and private insurance companies to move away **from a fee-for-service payment model** to making one single payment for all services associated with a specific episode of care.

- The cost of a patient's office visits, tests, treatments and hospitalizations associated with a specific illness, medical event, or condition are rolled or **"bundled" into a single, "episode-based" payment** to providers.

- The model is designed to **reward** physicians, hospitals and other providers who give patients **high-quality care at an appropriate cost**.

- If the cost of care is lower than the bundled payment, providers may share the savings. However, providers absorb the loss if costs are greater than the payment.

State Innovations: Payment Models – Arkansas (Cont.)

- How the model works
  - Patients experiencing one of the **medical episodes** defined in the model will schedule office visits and be seen by their physician or mental health provider just as they are today.
    - Examples of medical episodes considered in the model include COPD, Asthma, Upper Respiratory Tract Infection, Total Joint Replacement, ADHD/ODD Co-Morbidity, Congestive Heart Failure.
  - Providers will **file claims** as usual and be reimbursed as they are today.
  - A **provider portal** allows providers to access **reports that show the overall quality of care** they delivered during a set time period -- typically one year -- and at what average cost.
  - Medicaid and the private insurers use information from the portal along with claims data to determine which provider has the most responsibility for a given episode; designated as the **Principal Accountable Provider (PAP)**
  - At the end of the set time period, each **PAP's average cost per episode** will be calculated and **compared to "acceptable" and "commendable" levels of costs**.
  - If the average cost is above the acceptable level, the provider will pay a portion of the "excess" costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer

- The Arkansas payment reform initiative is now part of a larger initiative to implement medical home and health home models of care.

State Innovations: Arkansas Health Care Independence Act and 1115 Waiver

- As provided for by the **Arkansas Health Care Independence Act**, Arkansas filed an 1115 Waiver proposing to use premium assistance payments for certain eligible Medicaid beneficiaries to select **Qualified Health Plans (QHPs)** offered through Arkansas' Partnership Exchange – coverage plan known as the "Private Option."

- Private Option eligible beneficiaries are adults ages 19 to 64 who earn between 17% and 138% of the federal poverty level (FPL).

- **QHPs** will be certified by the Arkansas Insurance Department's plan management process to provider silver plans to eligibles receiving premium assistance payments through the Private Option.

- Medicaid beneficiaries receiving coverage through the premium assistance program will be included in the exchange risk pool – not the Medicaid risk pool.

- All **QHPs** are required to participate in the newly established Arkansas Health Care Payment Improvement Initiative (AHCPII).

Arkansas Health Care Independence Act and 1115 Waiver (Cont.)

- Co-pays
  - No cost sharing during the first year for those with incomes **below 100% FPL**
  - Cost sharing for those with incomes **between 50% and 100% FPL** in years 2 and 3
  - Cost sharing for those with incomes **between 100% and 138% FPL** will comply with a 5% of income cap on an annual basis and will be structure in a manner similar to cost sharing that applies to those receiving federal subsidies

- Arkansas will pay **QHP issuers** advance monthly cost-sharing reduction payments to cover the costs associated with the reduced cost-sharing for Private Option beneficiaries to be settled at the end of the year.

- Other Provisions:
  - Institute **12-month continuous eligibility**
  - Provide **wrap-around services** (NEMT, EPSDT, FQHC services and family planning services)
  - Follow **exchange review** criteria
  - **No HIPP** component to the **1115 Waiver**
  - Ensure two **QHPs** are available in each market area
  - **Medically frail** will not be enrolled in the Private Option; enrolled in traditional Medicaid program

State Innovations: Arkansas Health Care Independence Act and 1115 Waiver (Cont.)

- The **Health Care Independence Act (HCIA)** provides for the following revisions to the waiver:
  - May expand Private Option to adults under 17% FPL and children.
  - Optional health savings account and a high-deductible health plan pilot program called "Independence Accounts" for low-income Arkansans.

Appendix 1(d): MO HealthNet Cost Sharing

MO HealthNet Cost Sharing

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

July 31, 2013

Current Cost Sharing: Co-Payments

- Missouri's Medicaid Fee-For-Service program includes co-payments for most adult participants as allowed under federal and state law.

- The following adult participants are exempt from co-payment requirements:
  - Pregnant women
  - Residents of nursing homes
  - Blind persons
  - Medicaid/Medicare dual eligibles when Medicare pays for the service

- Total cost sharing may not exceed 5% of a family's income.
  - Family of two with income @ 19% FPL ($2,947) = $147
  - Family of three with income @ 19% FPL ($3,711) = $186
  - Family of one with income @ 85% FPL ($9,767)= $488
  - Family of two with income @ 85% FPL ($13,184) = $659

- Certain services are exempt from co-payments.
  - Emergency room care when life threatening conditions present
  - Personal care services
  - Mental health services
  - Certain therapies (physical therapy; chemotherapy; radiation therapy; chronic renal dialysis)
  - Hospice
  - Emergency or transfer inpatient hospital admissions
  - Family planning

Current Cost Sharing: Co-Payments (Cont.)

- The healthcare provider is responsible for collecting co-payments and provider reimbursement rates are set assuming that co-payments are collected.

- A Medicaid providers cannot deny services to MO HealthNet participants who do not pay co-payments; thus, providers view co-pays as the equivalent to reimbursement rate reductions.

- Current co-pays are capped at $3 for most services and $2 for pharmacy services according to the following schedule:

Medicaid Payment for Each Item of Service	Recipient Co-Payment Amount
$10 or less	$0.50
$10.01-$25	$1.00
$25.01- $50	$2.00
$50.01 or more	$3.00

- Co-payments for inpatient hospital services are charged at the rate of $10 per hospitalization.

Current Cost Sharing: Premiums

- Certain MO HealthNet Ticket to Work participants and Children covered under the Children's Health Insurance Program (CHIP) pay a premium to participate in MO HealthNet.

- Ticket to Work
  - Participants with incomes above 100% FPL pay a premium to be eligible for health care services under the Ticket to Work program.
  - 78% (or 1,040) of participants in the Ticket to Work program are required to pay the premium.
  - Mental health services and home and community based services account for nearly 50% of the health care costs of this group.

- CHIP
  - Children covered under CHIP with family incomes between 150% FPL and 300% FPL pay a premium to participate in the program.
  - For a family of three, the premium ranges from $23 to $183, depending on the income of the family.
  - 39% (or 28,000) of children participating in the CHIP program are required to pay a premium.
  - Over half of the children in families required to pay premiums have incomes between 150% FPL and 185% FPL (16,000 of the 28,000).

New Medicaid Cost Sharing Provisions

- In early July 2013, CMS issued a final rule meant to simplify what cost sharing limits states may impose under the Medicaid program.
  - The healthcare provider is still required to collect the co-payment.
  - Cost sharing is still subject to an aggregate limit of 5% of a family's income.

- New cost sharing allowances

Service	Family Income to 100% FPL	Family Income from 100% FPL to 150% FPL	Family Income > 150% FPL
Outpatient Services	$4 (starting in 2015), to be increased by the medical care component of the CPI	10% of cost the agency pays	20% of cost the agency pays
Inpatient stays	$75	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for entire stay

Service	Family Income to 150% FPL	Family Income > 150%
Preferred Drugs	$4	$4
Non-Preferred Drugs	$8	20% of the cost the agency pays
Non-emergency use of an emergency department	$8	No limit

Appendix 1(e): Missouri Medicaid Initiatives and Administration

MO HealthNet Financing and Administration

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

August 7, 2013

Prepared by the Missouri
Department of Social Services

MO HealthNet Financing

- The federal and state governments have shared responsibility for financing the Medicaid program.

- The Federal Medical Assistance Percentage (FMAP) is the federal share of Medicaid financing.
  - A state's FMAP is calculated annually by a formula that compares a state's average per capita income level with the national income average.
  - The FMAP varies by state, ranging between 50% for wealthier states and 80% for states with lower per capita income.
  - Missouri's Federal Fiscal Year (FFY) 2013 FMAP is 61.37%; the FFY 2014 FMAP will be 62.03%.

- State share sources to finance the Medicaid program include
  - General Revenue (GR) or GR equivalent (including provider tax proceeds) appropriations
  - Inter-governmental transfers (IGTs)
  - Certified public expenditures (CPEs)
  - There is no upper limit on federal funds to finance the Medicaid program; the level of federal funding available to a state is based on the amount of state match.

- States operating Children's Health Insurance Programs (CHIP) receive an enhanced FMAP.
  - Missouri's Federal Fiscal Year (FFY) 2013 enhanced FMAP is 72.96%; the FFY 2014 enhanced FMAP will be 73.42%.
  - Unlike the Medicaid program, CHIP funding is capped.

MO HealthNet Financing (Cont.)

- The federal government shares 50% of the cost to administer the Medicaid program and 75% to 90% of the cost to develop and operate information systems to administer the Medicaid program.

- A state's Medicaid State Plan describes the Medicaid program costs the federal government will help pay.

- The HHS Secretary has authority to waive certain provisions of law governing Medicaid and CHIP to allow for new ways to deliver and pay for health care services under theses programs.

- Medicaid waiver types include:
  - **Section 1115 Demonstration Waivers** for research and demonstration projects designed to temporarily test expanded eligibility or coverage options.
  - **Section 1915(b) Managed Care Waivers** which allow states to develop Medicaid managed care plans
  - **Section 1915(c) Home & Community-Based Waivers** which allow beneficiaries to receive long-term care benefits outside of institutional settings

MO HealthNet Financing (Cont.)

- Certain providers qualify for additional payments based on their designation in the Medicaid program.

- Upper Payment Limit (UPL)
  - The Upper Payment Limit is the federally established "upper limit" or maximum a state Medicaid program may pay a type of provider in the aggregate.
  - The "upper limit" refers to a reasonable estimate of the amount that would be paid for the services furnished by the provider group under Medicare payment principles.
  - States are allowed to receive and pay certain providers federal funds (if state matching funds are available) for the difference between the state's Medicaid reimbursed amount and the "upper limit."

- DSH (Disproportionate Share Hospital Payments)
  - Federal law requires state Medicaid programs to make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.
  - Federal law establishes an annual state-specific amount of federal funds available for total statewide DSH payments for hospitals (the DSH allotment); a state match is required to receive the federal funds.
  - Federal law limits federal funds for DSH payments to the hospital's eligible uncompensated care cost. States are required to submit an independent certified audit and an annual report to the Secretary describing DSH payments made to each DSH hospital.
  - FY13 Missouri DSH allotments are $511 million for hospitals and $207 million for Department of Mental Health hospitals.
  - DSH reductions effective October 2014; 5% first three years, 15% fourth year and 50% thereafter.

MO HealthNet Administration

- 234 FTE in the MO HealthNet Division are responsible for daily administration of most components of Missouri's Medicaid program.
- The Department of Social Services' (DSS) Finance and Legal Divisions provide support for the MO HealthNet Division.
- Medicaid provider enrollment and audit/compliance functions are a part of the Missouri Medicaid Audit and Compliance (MMAC) unit (82 FTE) under the DSS Director.
- DSS is the "Single State Agency" for Missouri's Medicaid program.
- Other Missouri state departments with expertise and responsibility for programs centric to certain MO HealthNet participants' health care needs administer certain Medicaid services.
  - The Department of Mental Health administers mental health programs for Medicaid participants.
  - The Department of Health of Health and Senior Services determines eligibility for long-term care services (nursing facility/community options) and administers home and community-based services for Medicaid participants.
  - The Department of Elementary and Secondary Education administers the First Steps program for Medicaid participants.

MO HealthNet Administration (cont.)

- MO HealthNet Division functions are highlighted in the chart below.

Operations	Finance	Evidence-Based Decision Support	Information Systems
Clinical/Pharmacy Policy and Operations	Institutional Reimbursement	Evidence -Based Clinical Decision Development and Support	Claims Adjudication and Prior Authorization
Managed Care Contract Management / Operations	Rate Setting (Managed Care, PACE, NEMT)	Clinical and Quality Research	Data Analytics for Decision Support and Medicaid Research
Federal Waiver Programs	Federal Waiver Financing	Managed Care / FFS Quality	Medicaid HIE/HIT
Participant Services	Budget / Financial Operations	Physicians and Clinics	Interdepartmental IS/IT Integration
Provider Education	Provider Taxes	Psychology Program	
Exceptions	Medicare Buy-in / HIPP	Patient Centered Medical Home	
Pharmacy Rebates	Cost Recovery		

MO HealthNet Administration (Cont.)

- The Medicaid Management Information System (MMIS) is the claims processing engine for Medicaid payments.

- Providers submit claims for payment under the fee-for-service program.
  - Pharmacy claims are adjudicated real time at point of sale.
  - Other claims are paid twice monthly.
  - Under prompt pay requirements, Medicaid programs are required to pay 90% of clean claims within 30 days of receipt and 99% of all other claims within 90 Days for receipt.

- Prior to payment, claims go through a number of edits to ensure payments are made in compliance with MO HealthNet policies and evidence-based protocols.

- Cyber Access and clinical decision support tools allow providers to determine if a service is allowable for payment prior to delivering that service.
  - Prior authorization / Pre-certifications
  - Prescriptions, Durable Medical Equipment (DME), optical services, inpatient hospital stays, imaging services.

Appendix 2: Comments by Cale Bradford

September 9, 2013

To: Representative Noel Torpey, Chairman
House Interim Committee on Medicaid Transformation

From: Cale Bradford, Citizen Member
House Interim Committee on Medicaid Transformation

RE: Observations on Expansion and Reform of Medicaid

In my travels as a citizen member of the House Interim Committee on Medicaid Transformation this summer, I've made a few observations; the most important of which are, 1) expansion of Medicaid is an issue the effects the working poor predominantly and is by a huge margin the preference of all the Missourians that testified in front of our committee, 2) The issues of Medicaid expansion and Medicaid reform are not necessarily coupled issues. For example, managing the care of Missouri's dual eligibles, perhaps the single biggest area in which to achieve the full financial benefits of reform does not, in any way, impact Missouri's expanding Medicaid nor its receiving or not receiving the additional federal funding associated with Medicaid expansion. There is no artificial ticking clock on Medicaid reform.

This is important because it means Missouri does not have to resolve every aspect of our Medicaid issue in a single, omnibus initiative. We have the necessary the time to consider the pros and cons of all the potential avenues of reform; and given the long term cost and numbers of individuals involved the matter it deserves a studious consideration of our options.

Reform should Mean Better Management of Dual Eligibles:

Medicare covers 46 million elderly and disabled Americans. 10.2 million Americans are also covered by Medicaid. They are in the parlance of public health, "Dual Eligibles." 7.4 million of these, our poorest sickest citizens, are considered "Full-Dual Eligible." These individuals are using the full benefits available to them under both Medicare and Medicaid. 61% are over 65, 39% are younger than 65 and disabled. Half have dementia or another mental impairment and 55% have three or more chronic conditions. This is the highest cost group of consumers in the American medical system. They are 18% of the Medicaid population in Missouri and account for 43% of total Medicaid spending. There are 168,229 full dual eligible in Missouri and Missouri Medicaid spends in excess of $3 billion annually on their healthcare.

So who pays for what? Medicare pays for most acute care services like hospitals and physicians, but also prescription drugs and certain post acute services like rehabilitation in a SNF, home health, some outpatient therapy and some DME. Medicaid pays the individual's Medicare premiums, cost-sharing for acute services, and for services not covered by Medicare, most notably long-term care but also medical transportation, case management, and in some states vision and dental services.

Because Medicare and Medicaid pay for different slices of dual eligible's care this group's services have been largely uncoordinated. The cost of investments designed to improve health outcomes and lessen overall spending, if done at all, is often borne by the State and Medicaid with the financial benefits accruing to the Federal government and Medicare. For example, reducing avoidable hospitalizations is a direct benefit of better coordinated care. CMS says 45 percent of hospitalizations transferring from skilled nursing facilities in 2012 we're avoidable. To reduce those hospitalizations requires investment in programs like fall prevention and expanded HCBS services. The cost of expanding these programs is roughly 40% born by the State under Medicaid but the financial savings from those investments accrue to Medicare and the Federal government.

To address this inequity, The Affordable Care Act created the Medicare-Medicaid Coordination Office within (CMS). Their goal is to make the two programs work together more effectively. They are charged with testing new approaches to care coordination. These initiatives allow states to keep any earned Medicaid savings but also share in the Medicare savings resulting from their management efforts. The biggest of these initiatives is the Financial Alignment Demonstration. In this demonstration CMS is testing predominantly two models to better integrate primary, acute, behavioral health, and long-term supportive services for full dual eligibles. The Medicare- Medicaid office wants 2 million of the 7.4 million full-dual eligible Americans enrolled in these demonstrations by the end of 2014.

The two models being tested by the Financial Alignment Demonstration are:

- **The Capitated Model**. This is a model that pays private health plans that contract with the state a PMPM rate to provide all Medicare and Medicaid benefits to full dual eligible on behalf of the state.

- **Patient Centered Medical Home Model**. This model allows states to design systems to coordinate care for full dual eligibles while Medicare and Medicaid continue to pay providers directly for delivered services.

So what's the difference? The Capitated model and the Patient Centered Medical Home model are both, equally, managed care models. Operationally, the capitated model, through capitation, transfers the risk of financial loss from the state and federal government to a private third party who administers the program to control cost and provider behavior. The Patient Centered Medical Home Model addresses cost and provider behavior by establishing a single point of coordination to design and manage care plans, case manage individuals, and coordinate all services. It then shares a portion of total system savings with providers who meet its quality and cost benchmarks.

As of March 2013 26 states have submitted proposals and 5 have executed memorandum of understanding with CMS (California, Washington, Ohio, Illinois, Massachusetts). The other states remain in negotiations with CMS. Missouri submitted its proposal on May 31st, 2012. Missouri chose to submit a Patient Centered Medical Home Model. Of the currently approved

Appendix 3: Comments by Steven Edwards

CoxHealth

August 30, 2013

Missouri House Interim Commission on Medicaid Transformation

The committee is considering the options and principles for Medicaid "transformation." I believe that we should recognize the new Medicaid funding allocated to Missouri as an opportunity to both reform and strengthen the state's current Medicaid program. Done properly, this funding can be creatively targeted to strengthen care coordination, better align incentives, and promote quality and efficiency through multiple delivery and compensation models.

There is no shortage of opportunities to improve the state's health care delivery and financing system and to make Missourians healthier.

- A comparison of health indicators and outcomes among the states in 2012 ranked Missouri at 42nd, a significant drop for the state over the past several decades.
- Every minute of every day, an uninsured person seeks care from a Missouri hospital.
- Too many psychiatric patients seek care in hospital emergency departments and do not have a place where they can be referred for needed treatment.
- Life expectancy differs dramatically among those living in close proximity.

A key theme for all of those who are charged with managing health care delivery is to improve the accountability of the health care system. There are numerous examples being implemented today by the federal government — value-based purchasing for hospitals in the Medicare program, penalties for "preventable readmissions," etc. The private insurance market is following suit. A common focus of these initiatives is to transition away from traditional "fee-for-service" payment systems to delivery models that better reward efficiency and patient outcomes and "value."

As this transition continues and expands, it is important to focus on the importance of care coordination and to target that effort to those patients who generate a disproportionate share of health care costs. According to data from the Missouri Hospital Association's Hospital Industry Data Institute, in fiscal year 2012 five percent of Missouri Medicaid enrollees incurred 52.3 percent of Medicaid hospital costs. The distribution of costs among non-Medicaid patients was only slightly lower; five percent of patients generated 50.3 percent of their hospital costs.

The challenge, then, is to identify those very high-cost patients and better manage how they interact with the health care system.

An Equal-Opportunity Employer. Services provided on a nondiscriminatory basis. Patient admissions, room assignments and patient services are provided without regard to race, color, national origin, disability or age.

A promising means for doing so involves the use of primary care "health homes." They are responsible for coordinating the services that higher-cost patients receive. As our committee has learned from testimony, there is a Medicaid demonstration project being implemented by the Missouri Medicaid program that serves tens of thousands of Medicaid patients. My organization participates in this demonstration; we believe that it offers some of the best prospects for improving the efficiency and effectiveness of the delivery system.

A second provider-driven model for managing care is the accountable care organization model. ACOs assume the responsibility for managing a selected patient population and can qualify for shared savings if the ACO controls costs while meeting defined quality of care performance metrics. Some ACO arrangements also include shared risk for providers. ACOs are in place in the Medicare program and are growing rapidly in the private insurance market. The national insurer United Health Care recently announced that it plans to have $50 billion of its contractual arrangements with health care providers arranged through the ACO model. A number of other states are implementing ACOs in their Medicaid reform initiatives.

Many in the provider community believe, as do I, that the prospects for success in "transforming" the delivery system by improving coordination of care are much greater when they are designed and implemented by the health care providers who are delivering the care. The traditional HMO insurance model has had its day, but has a dwindling share of the commercial market. The Medicaid programs of various states continue to use and even expand this historical delivery model, but it is not clear from the data that it offers significant benefits in terms of cost or quality of care. In a future that will increasingly emphasize accountability for results, many providers believe that the results will be clearer and better in provider-sponsored models of care than those are managed as insurance networks with traditional networks of captive providers.

Sincerely,

Steven D. Edwards
President & CEO
CoxHealth

Appendix 4: Comments by John Ellena, MD

BJC HealthCare

Senate Interim Committee on Medicaid Transformation and Reform

Testimony Submitted by Dr. John Ellena, Chief Medical Officer for the BJC Medical Group

August 14th, 2013 in Jefferson City

I. Overview of Accountable Care Organizations (ACOs)

a. ACOs were developed through the Medicare Shared Savings program in which the federal government is targeting $1B in savings over 4 years across the entire continuum of care by improving care coordination. Savings can be in the form of hospital and/or professional fees and can be achieved through reduced admissions, reduced readmissions, and reduced ED visits, testings, and procedures.

b. ACOs are legal structures that permit for "joint decision making" among groups of doctors, hospitals, and other health care providers, who come together voluntarily to be held accountable for and give coordinated high quality care to a specific group of at least 5,000 Medicare beneficiaries assigned by CMS. Patients must be informed that they are participating in the ACO and maintain a freedom of choice of providers. Patients may also decline CMS permission to share claims data. Presently 4 million traditional Medicare beneficiaries (10%) are managed by one of the approximately 200 ACOs throughout the country.

c. The goal of coordinated care through the ACO is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services/costs and preventing medical errors. If an ACO is able to demonstrate both increased quality and reduced costs among the population of Medicare patients they are assigned, then the ACO providers are able to retain 50% of the savings realized.

II. About the BJC ACO

a. BJC's ACO began in 2012 as a shared savings ACO. The focus of the BJC ACO is to achieve National Committee for Quality Assurance (NCQA) Level III Patient-Centered Medical Home accreditation for all 43 BJC Medical Group primary care physician practices.

b. The vision of the BJC ACO is to take better and more coordinated care of seniors. This is important because seniors are a growing part of our population and utilize the most care. We have a time-limited opportunity through the ACO to utilize tools through Medicare and remove barriers to care that will allow us to provide better care at a lower cost. We believe these tools are essential for our future success. Through this process, we believe that we can improve patient access, enhance patient education and record sharing, place a greater emphasis on referral tracking and follow-up, continue our use of Electronic Medical Records, improve care coordination, and better address gaps in care. <u>When we are successful, patients will experience better health, our community will have better healthcare and we will be providing better value. We will have a healthcare system that others will want to emulate or join.</u>

c. Since the inception of the BJC ACO, we have learned that improved care coordination is dependent upon establishing a strong and continuous relationship between the patient and the physician. Scheduling routine primary care visits, increasing the availability of and access to providers by extending physician office hours, establishing an individual year-long care plan during the annual Medicare Wellness Visit, assigning care managers to high-risk patients, and ensuring post-discharge follow-up are several ways in which we have found that improved care coordination can be achieved. As one specific example of improved ACO care management in practice, we have learned that health outcomes can be improved by

alerting primary care physicians when their patients, particularly those who are deemed "high-risk", are admitted to the emergency department and the physicians are allowed to intervene in their care.

d. Aside from changes in care coordination practices, the BJC ACO has also taught us the importance of eliminating unnecessary variation by standardizing workflow processes, increasing clinical data integration, and utilizing data mining. It is essential for healthcare providers to share their notes and for the data to be able to follow the patient through a single chart contained within an integrated technology system.

e. As we continue to improve the ways in which we manage population health through the BJC ACO, we will explore the possibility of integrating ambulatory services in care management, coordinating with primary care providers to offer post-discharge support to prevent hospital readmissions, and expanding hospital-based services beyond the hospital walls. With regards to expanding hospital-based services specifically, we are considering developing hospital-sponsored care teams including care management, social workers, and therapists that are partnered with their sponsored primary care physicians. These PCP/hospital combined care teams can then serve as medical homes for patients in our community, increasing visit volume and reducing leakage to neighboring healthcare providers.

Appendix 5: Comments by Representative Diane Franklin

CAPITOL OFFICE

State Capitol, Room 206B
201 West Capitol Avenue
Jefferson City, MO
65101-6806
573-751-1119
E-Mail:
diane.franklin@house.mo.gov

Legislator Assistant
Marybeth Bruns
E-Mail:
marybeth.bruns@house.mo.gov

Missouri House of Representatives

Diane Franklin

State Representative
District 123

COMMITTEES

Health Care Policy
Vice-Chair

Appropriations- Education

Agri-Business

Professional Registration and Licensing

Administration and Accounts

August 22, 2013

Interim Committee on Medicaid Eligibility and Reform

This committee heard testimony about shortages of primary care physicians(PCP), physicians frustration with quality of care for the chronically ill due to high demands on their schedules, patients testified about lengthy commutes, difficulty getting appointments, long office visit wait times, and at times the need to see a specialist where often all of the aforementioned frustrations were repeated.

Are we willing to do something different than the typical value for service? YES! It is indeed possible!

I hope you will indulge me and take a few minutes to look at technology we are already utilizing but with some knowledge based resources and interaction on the statewide and community levels – this model could be part of the solution for Missouri.

On Tuesday, August 20, 2013, former State Representative Dr. Wayne Cooper and I participated in a live video conference with Dr. Arora. Dr. Arora in conjunction with the University of New Mexico has developed **Project ECHO**. The conference which is held on a monthly basis was attended by other healthcare professionals, elected officials and educational leaders from all across the country and internationally as well. The conference was informative and inspiring. http://echo.unm.edu/index.html This website explains the ECHO Project. Please take 10-15 minutes to look around this site; you will quickly learn this is a sound concept for Missouri to simulate.

In my opinion, the ECHO Project provides the theory for a segment of a much needed solution to
1. Primary Care Physician shortages and
2. Travel and time elements that patients and physicians currently navigate

The ECHO Project provides for an extension of the PCP knowledge and learning through the utilization of community health workers (CHW). Neither the patient nor the PCP needs to leave their local community. An example of Medicaid costs for an office visit to a PCP in an underserved area: The physician is reimbursed by Medicaid $100 for the office visit. Medicaid pays for $500 in transportation costs for the patient to travel to the clinic. Often times the patient is accompanied by a relative that must take leave from their employment to assist the patient. Telemedicine via Project ECHO provides the patient a multi-leveled degree of care at a substantially lower cost. As legislators if we could develop this model for our state we could address could provide better care for our rural citizens and address the shortage of physicians in the underserved areas of Missouri – not simply the I-70 corridor of counties but the entire state.

I hope by reading this I have inspired you or at least made you a bit more curious and created the desire for you to learn more about Project ECHO. On the next page are some points I pulled from the ECHO website.

Dr. Arora's mission is simple – in his own words - A significant change in the way we treat common, chronic, complex diseases was needed.

"In 2002, Sanjeev Arora, MD, a physician at UNM Hospital and one of the few hepatitis specialists became increasingly frustrated with his inability to provide care to the thousands of New Mexicans who suffer from hepatitis C.

"I could only treat 70-90 hepatitis C patients per year in my clinic and there were more than 30,000 people with the disease in the state," he says, adding that there was a six-month waiting list for patients to see him. And these were the lucky patients the ones who lived near Albuquerque or could afford the luxury of traveling to see a specialist on a monthly basis for the year-long treatment.

Treating hepatitis C is a complicated process; it takes many years to develop this special expertise and very few physicians in New Mexico have it. In rural and medically underserved areas, proximity to specialists, a limited number of specialty providers and inadequate medical insurance severely limit a patient's ability to seek specialty care. This meant that thousands of rural patients across the state who did not have access to a specialist or the means to gain access would largely go untreated. To Arora, this was unacceptable. "I asked myself if there was something I could do to make a difference," he says."

The ECHO Model™ dramatically improves capacity and access to specialty care for rural and underserved populations.

- *Uses technology to leverage scarce healthcare resources*
- *Supports best-practice care*
- *Reduces disparities and variation in care*
- *Utilizes case-based learning strategies*

Use the ECHO model™ to improve quality of care and reduce total cost of care. Increase overall primary care capacity to diagnose and provide the best treatment for high-need and high-cost Medicaid beneficiaries with Chronic Conditions.

After listening to the needs and concerns expressed by citizens that have testified before our committee and studying the results of Project ECHO – this is what I view as potential outcomes for the citizens of Missouri:

Benefits for Patients:

This is not simply telemedicine with the patient sitting in front of a monitor with a nurse practitioner – this is a peer to peer exchange of knowledge of the condition by PCP and if warranted a Specialist. In the case of chronic conditions were the patient needs ongoing knowledge as in diabetic care, pain management, Hepatitis C or Mental Health - The patient gains a community based level of healthcare. Example: If the PCP utilizes the ECHO model of Outpatient Intensivist (OIT) Teams which are comprised of: a Nurse Practitioner or Physician Assistant, Registered Nurse, Behavioral Health Counselor/Social Worker, two Community Health Workers, and part time Physician as well as administrative support. These OITs will provide in-home and office-based primary care as well as care management and coordination for their patients. The ability to provide care "where the patients are" will greatly enhance the ability of the patients to receive help "when they need it and where they need it".

Benefits to Rural Clinicians:

Professional interaction with colleagues with similar interest (Less isolation with improved recruitment and retention, ability for part-time PCP to practice) Greater ease of collaboration-access to consultation specialty physicians, pharmacist, patient educator. In the residency training programs more exposure to the specialties. Recruit and retain PCP to show that care given in this setting is as safe and effective as that given elsewhere.

Finally, Project ECHO hosts live monthly video and telephone conferences. If you are interested in participating in this, please let me know.

Diane Franklin
District 123

Appendix 6: Comments by Chris Gray

Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

Testimony by Christopher Gray, Executive Director

Missouri Council of the Blind

It has been an honor to travel the state and serve with such a fine group of dedicated and knowledgeable committee members in the field of health care, Medicaid coverage, hospital administration and the provision of care to Missouri citizens. The knowledge we have gained from one another and from those who came to testify before us cannot be overestimated!

As a representative of the Missouri Council of the Blind and a blind person myself, I would like to offer final written testimony on the following key elements regarding Medicaid reform and expansion:

- General Comments
- Medicaid as it relates to the blind community
- Spend down

General Comments

There can be no question that the vast majority of those who testified favor Medicaid expansion and are supportive of ideas to reform and improve the system as well. As a corollary to this, no coherent reasoning was ever presented to the committee to show that expansion and transformation cannot be undertaken in a single package right now.

Second, one cannot help but be struck by the person-oriented aspect of Medicaid services and expansion. We are told that two Missourians die each week because they have no medical coverage. Surely, we can do better than that in our state. What makes this an even sadder reality is the testimony provided suggesting that those who will be most helped by Medicaid expansion are the working poor of the state, people with 2 to 3 part-time jobs and who work in fast food and for companies such as Walmart.

Regarding Medicaid transformation, an impressive amount of work has already been started in Missouri to get such reform under way. The concept of the health care home is shown to be effective and could well be the single most important innovation in health care in the past thirty years.

Finally, we as a committee heard over and over again how important specialized services are for specific sectors of healthcare recipients. Those supporting the mentally ill asked for a carve-out to serve their population. Similarly to those who suffer mental illness, those with sensory disabilities, particularly the deaf and the blind, know all too well how critical specific protections based on their disabilities is to the potential success and physical well-being.

Recommendations:

1. Consider groups such as the blind, deaf and mentally ill separately while crafting Medicaid expansion and transformation. Each group has their distinct issues and needs.

2. Give priority to the Healthcare Home model which emphasizes medical services and outcomes over managed care which too often denies desperately needed medical assistance.

Medicaid and the Blind Community

It is important to recognize that a significant portion of the blind community has disabling conditions in addition to their blindness. This was true of virtually every blind witness who testified before the committee. Key witnesses who discussed this issue were Marti Watson, Corey McMahon and Debra Corman, along with many others. It should be remembered also that diabetes is the leading cause of blindness in adults and that macular degeneration adversely affects the vision of people as they age. Such multiple disabilities make employment difficult though it should be emphasized that many blind people do work or attempt to work on at least a part-time basis.

Employment for the blind is difficult to attain. As a disabled population, we have the highest unemployment rate at a level estimated at about 70-75% by the American Foundation for the Blind. This situation forces many blind people to rely on Medicaid services, not by choice but by necessity. For those subject to "spend down", the risks of taking even part-time employment often outweigh the benefits.

Recommendations:

1. Provide necessary durable equipment related to secondary disabilities in addition to blindness. A prime example of a need here is hearing aids for those who are already blind and suffering moderate to severe hearing loss.
2. Consider blind recipients as a recognized category of individuals needing specialized Medicaid provisions. This is due to multiple disability issues and lack of available employment for people with this sensory disability.

SpendDown

Missouri residents who receive the blind pension are automatically eligible for Medicaid services without regard to income. However, recipients of Supplemental Aid to the Blind are subject to Medicaid income guidelines and Missouri SpendDown provisions. MCB is aware of many cases where SpendDown exceeds the amount provided by Supplemental Aid to the Blind. In one case for example, a person receives $711 for Supplemental Aid but has an accompanying SpendDown of $750. In another case, an elderly blind man's SpendDown exceeds $1,200 per month. Those who cannot feasibly pay these amounts simply go without medical coverage or use Medicaid sporadically to the detriment of their overall health.

The implementation of SpendDown is an administrative nightmare for blind people in that much paperwork unavailable to them directly must be maintained. Monthly payments and the administration of such payments creates delays, confusion and often unavailability of medical services.

Recommendations:

1. It is our fervent hope that the legislature will consider alternatives to SpendDown such as the Medicaid Buy-In Program and alternatives used in other states.
2. Short of reforming SpendDown, we ask that a blanket exemption to SpendDown be considered for blind Medicaid recipients.

Appendix 7: Comments by Kathleen Haycraft, DNP, FNP/PNP-BC, DCNP

Citizens Medicaid Transformation Committee Recommendations from Kathleen Haycraft

1. Reintroduce Rep Barnes bill (138% FPL) with appropriate adjustments for individuals with disabilities.
2. Create coordinated care models for high-risk high, yield populations e.g., mental health, urban poor.
3. Create cost models that clearly contrast the cost of the churn effect with the cost of the woodworking effect.
4. Utilize the super-utilizer model in both hospital and outpatient settings. Provide incentives to create these models.
5. Link funding of hospital Medicaid payments to the ability to provide appropriate mental health services.
6. Tread carefully in the managed Medicaid model as a savings associated with increased overhead can only be achieved by reducing services to patients and/or reducing payment to providers who are already limiting acceptance of Medicaid patients.
7. Eliminate system imbalances that encourage prisoners to commit crimes or women to become pregnant to receive health care.
8. Carefully evaluate all regulations and their impact for cost. I would move up the review of health care regulations (Senator Dixon's bill) to the upcoming year and link it hand in hand with Medicaid. It was interesting that the cost of regulations at the Truman Hospital was equivocal to the cost of charity care. This is not sustainable. Monitor outcomes and not processes. When outcomes fall outside the norm, then look at processes.
9. Expand ticket to work programs while carefully monitoring expense and outcomes.
10. Instead of increasing primary care providers to chiropractors and paramedics, remove Missouri's APRN (nurse practitioner's) excessive restrictions to save money, increase access, and move the state on par with the rest of the nation. Referencing the Health Care Cost Curve in Missouri, this decision would save Missouri $1.6 billion dollar savings over the next decade.
11. Increase care in the home and increase patient centered home (not medical centered home). Patient needs should drive the system.
12. Enhance the ticket to work while watching for abuses.
13. Continue DM3700 to offer mental health services post prison
14. Kiosks are not practical for individuals who are seeking private sensitive care.
15. Maintain the critical rural and urban underserved access hospitals and health care systems.

Thank you for the opportunity to serve on this committee and to make my recommendations.

Kathleen Haycraft, DNP, FNP/PNP-BC, DCNP
Missouri Representative American Academy of Nurse Practitioners
Co-chair Missouri Council of Advance Practice Nurses

Appendix 8: Comments by Jerry Kennett, MD

BJC HealthCare

Monday, September 9th, 2013

Jerry D. Kennett, M.D.
Vice President and Chief Medical Officer, Boone Hospital Center
1600 E. Broadway
Columbia, MO 65201
First Floor, Box 44

Representative Noel Torpey
MO House of Representatives
201 West Capitol Avenue
Room 404B
Jefferson City MO 65101

Chairman Torpey,

First, I would like to thank you for your leadership and service on the House Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform. I am eager to see how the ideas expressed by citizens throughout the state can contribute to the General Assembly's discussion on Medicaid reform. As you requested, this letter discusses what I envision to be several opportunities for reform that have surfaced through both my experience on the committee this summer as well as through my role as the Chief Medical Officer at Boone Hospital Center and as a practicing cardiologist.

As the Affordable Care Act (ACA) goes into full effect, hospitals and physicians are facing significant fiscal challenges. Over the next three years (FY2014-FY2016), BJC HealthCare is projected to receive approximately $145.7 million less in federal reimbursement for the care we provide. The federal cuts already under way through the ACA, the American Tax Relief Act, and sequestration are not the result of the General Assembly's actions or inactions, however these are very real reductions which have begun to place serious financial strain on hospitals' throughout our state, including BJC HealthCare.

Though our challenges are substantial, health reform also presents Missouri with an incredible opportunity to reform the way healthcare is accessed and delivered in our state. One of the specific areas of opportunity that I would like to discuss is that of patient accountability and individual responsibility in health care. Recognizing that individuals will present at our hospitals regardless of their ability to pay, providers have started to "think outside of the box" in how we manage the care of the un- and under-insured. We believe managing the cost of this population requires incentivizing patients to use health care resources appropriately as well as ensuring flexibility for the providers who treat them. While providers aim to manage the health of Missourians, the state needs to be nimble in allowing patients to access health care at the right time and in the right setting. Patient accountability measures, if coupled with a transformation of how care is delivered to the un- and under-insured, may be a key solution in lowering costs while increasing both access to and quality of care.

Patient accountability can take many forms, however one particularly interesting concept is introducing accountability measures and outlining expectations during a patient's initial interaction with the health care system. Several health care homes in Missouri have made remarkable efforts to integrate patient accountability into their care management practices by requiring patients to sign a "patient rights and responsibilities" document. This document outlines the providers'

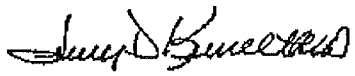
expectations that the patient will communicate with the provider, follow treatment plans prescribed, and respect the facility's standards of conduct. The exercise of discussing and signing an attestation of accountability helps to manage expectations for both the patient and provider from the very beginning. This is particularly important in getting patients to fill prescriptions, take their medications as prescribed and keeping follow up appointments rather than showing up at the emergency room having done none of the above.

Providers in Missouri are also making progress in fostering individual responsibility for the uninsured while they are in Emergency Departments (ED). For example, The Integrated Health Network in St. Louis employs Community Referral Coordinators who work with uninsured individuals who present at the ED for non-emergent care.[1] The Community Referral Coordinator helps to educate the patient on resources available for primary care and then assists them in scheduling primary care appointments and arranging transportation to the appointment if necessary. A similar concept was echoed in House Bill 700 in which Representative Jay Barnes proposed the idea of opening 24-hour urgent care clinics in EDs so that the uninsured have the access to the preventive and non-emergent care they would not otherwise have. While we are not confident that current federal law would remove the provider's obligation to "treat and triage" in the ED, we do believe that it is necessary to explore other options and solutions regarding emergency care in order to transform the way patients access the care they need.

In addition to his ideas on reforming the availability of urgent care clinics, Representative Barnes also proposed that patients could qualify for financial rewards when they seek less-costly care alternatives in these urgent care clinics as opposed to presenting at high-cost EDs. We know that when a patient has access to preventive care and is able to be treated at an urgent care site rather than an Emergency Department, not only do we see better health outcomes, but the costs of care are significantly lower. Such reforms have the potential to fundamentally transform the way the uninsured interact with the health care system. Building upon the progress already made by certain providers in Missouri and other states across our nation, I believe we should take this opportunity to develop state-wide solutions that foster accountability measures and incentives that encourage patients to take ownership in their health care.

It is clear that our Medicaid program requires reform to prevent the rapid acceleration in costs BJC and other providers have experienced and continue to see. It is also clear that there is a growing population of the working poor who cannot afford health insurance and deserve the ability to access care. Through the hearings held this summer, it is evident that the majority of citizens in Missouri favor Medicaid reform expansion when the concept is divorced from the Affordable Care Act. Reforming the current Medicaid program in Missouri to craft our solutions will is the right step forward and will allow us to achieve savings that will more than pay for Medicaid expansion in our state.

I greatly appreciate all the time and effort you have given to this committee and thank you for allowing me to participate. If I can be of assistance in any way, please feel free to contact me.



Jerry D. Kennett, M.D., MACC
Vice President and Chief Medical Officer, Boone Hospital Center
Senior Active Partner, Missouri Cardiovascular Specialists
jdk1249@bjc.org

[1] The St. Louis Integrated Health Network (IHN) is an alliance of primary and specialty medical care providers in the St. Louis region. The goal of the IHN is to ensure access to health care for uninsured and underinsured children and adults through increased integration and coordination of a safety net for health care. IHN providers serve 200,000 individuals in the St. Louis region each year for primary care through more than 400,000 encounters.

Appendix 9: Comments by P. Melton

P Melton

Medicaid Reform and Expansion

Thank you for choosing me to sit on this panel. As you know, I am not a political person, for many reasons I have chosen to use my vote for a president only one time in my life. So for me to offer to become involved with this was a huge step into the unknown world of politics. Because I have worked in the mental health field most of my life and also dealing with my own mental and physical issues as I have gotten older has taken me from a working, middle-class contributor to society to the other side as a recipient of Medicaid and Medicare. But I believe that God puts us where we are needed, so I use my education, work experience, and knowledge to help those who either cannot or do not know how to advocate for themselves through the maze of government rules and regulations.

As I listened to all the testimony the message that resounded was a definite" YES' to Medicaid expansion! Of course we heard some" No's", but they seemed to be based on statistics and financial loss or gain. Many who testified were disabled, elderly, and those who had worked all their lives but now was caught in the reality web of spin downs, denials and, in their eyes, of being punished for having the " American Dream" of owning a home, vehicles and all that they were told that they was suppose to obtain. Now that they need help from the same government that they paid their taxes to religiously they are blindsided by a letter of rejection because they did the "right thing"! I truly believe that the spend down program needs to be totally be reworked, a person who has worked and contributed should not have to choose between very needed medication and/or food or their spend down amount. I feel that Medicaid standards need to match Social Security standards for these people, that they should not have to sell everything they have worked so hard for just to pay into a system that they have already paid into! It should be more on an individual case than just across the board rules.

In this day and time the jobs that would provide for Americans and keep our economy stable have been allowed to be "outsourced" by large corporations. Why? Purely for more and more profit with no concern for the people who helped them get their businesses started, the American worker. And now, with a loophole in Obamacare, these large corporations are now using what was meant to help Americans, so they do not have to provide the basic care of their workers, insurance. How? By changing employees to "part-time", thus no benefits. And who will have to pick up all those who work so hard for a meager wage at best? Yes, the Missourians and the other states health systems. We CANNOT in good conscience refuse to provide for our working poor just because our government is being controlled by those huge, multimillion dollar corporations. Take care of our own NOW and then fight the "big dawgs" in the capital later is what has to happen.

And last we have to address the issue of so many young people who have no insurance, which a lot are chemically addicted adults. It is a sad fact that the job market that could have employed so many of this group with decent income and insurance has been been shipped overseas. Our country was built on manufacturing products, there was plenty of jobs for anyone who wanted a good life and was able to provide for their families, to live "The American Dream". But reality is that "American Dream" is no more. Now our young people struggle to find a job, let alone one that pays enough to survive on. So a young society who survive in a world of insecurity,

little job market, and increasing stress find something to make them feel better and change their reality, if just for a little while, and drugs and alcohol is what they turn to. We cannot **ignore** this growing issue, we **have** to step up and care for our young men and women, we have to have medical coverages and facilities that really treat this disease instead of a rotating door at emergency rooms because they have no way to obtain care to treat or prevent illnesses until they are so acute that they end up in hospitals. Who takes the brunt of paying for this care? Hospitals, doctors, and in the end, you do because your insurance premiums and physicians charges go up to cover their bottom line. With Medicaid expansion we can take care of all the above, our fellow Missourians, or even our families, because all it takes is one medical catastrophic event to wipe out a families savings and future!

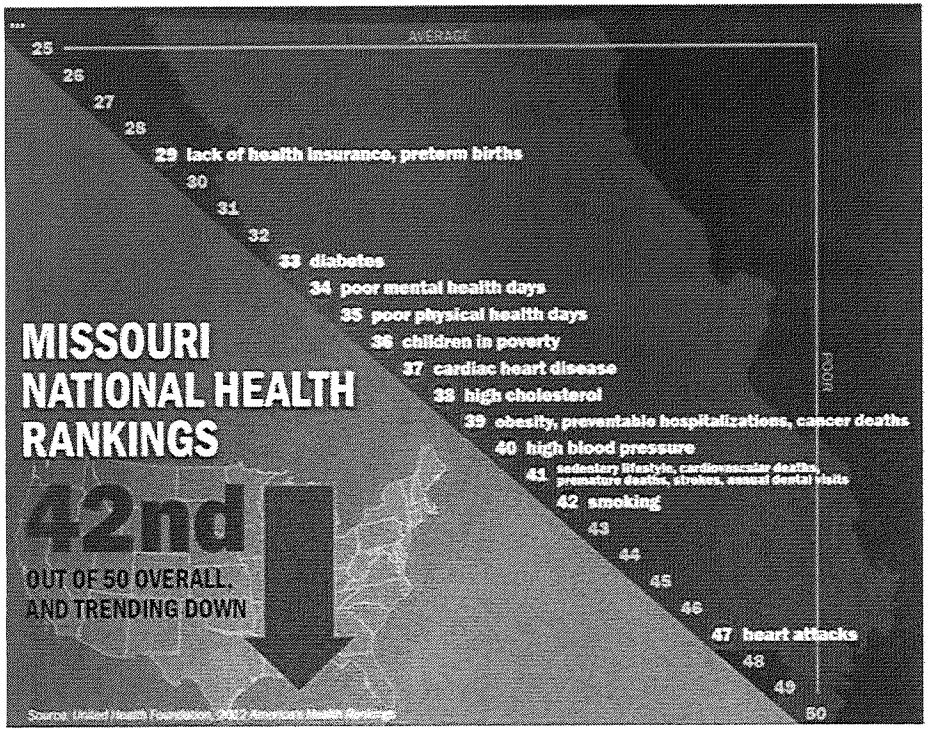
I understand the ones who say no, they look at figures and statistics, they see a future that is gloom and doom, and so do I. There is a bleak future for America that I foresee, another depression of such magnitude that we may not survive it, and ever growing thunder of a war that could be more than we can survive intact. I am a veteran, I served six years in an Intelligence Unit, which means I do not believe anything provided by the media, but all one has to do is just pay attention and the truth is there. This now, not the future of our country, this is OUR choice first as humans and then as Missourians, and what we have to do if we believe in any form of God is to care for the men and women who need us! To share our blessings! To remember" But for the grace of God go I" I also agree that the whole system need to be reworked. I use an example of the Jesus Christ of Latter Day Saints church uses for their members, if a member needs help they receive it, but they are encouraged and yes, expected to repay that help by working on the farms that grow food, or the other businesses that are owned and operated by the church, even if it's at their pantry or in used clothing store. I see many people who have generations raised on the "system", which means they are programmed into this mode. I would suggest a "work to receive program" where the recipient have to attend successfully some kind of program that teaches job skills needed in this economy,a technical skill not a college degree which takes four years and cannot guarantee a job. A testing program like Vocational Rehabilitation uses to fit the skills needed to the person. A program that offers the person a job above fast food and cleaning motel rooms, along with counseling, money management. One where the poor working person is not punished for making a little over that "invisible line" that the system has now. As the regulations are now, if a person makes over the "number" then the state start cutting all their benefits immediately, which means if you are poor and need the system to survive you tend to panic and then end of quitting just to keep the benefits you need to survive. A person needs positive reinforcement in life, not punished for trying! We have to find a way to encourage and reprogram a generation or two who have only known negative in life, we can change that and help them to become tax paying citizens who share pride in their accomplishments and life, instead of another generation of "slavery".

So in closing I hope I have shared what I heard from the multitude of those who testified, and from the every day person who I have made an effort to talk to on the streets and at restaurants, and shopping markets in the different areas that the meetings were held. I heard that help was needed and that was what Missourians did, help. I hope I have assisted in the very hard job before you. You and your committees hold the lives of many, many Missourians very lives in your hands. Please, do the right thing and vote yes.

Appendix 10: Comments by Sally Nance

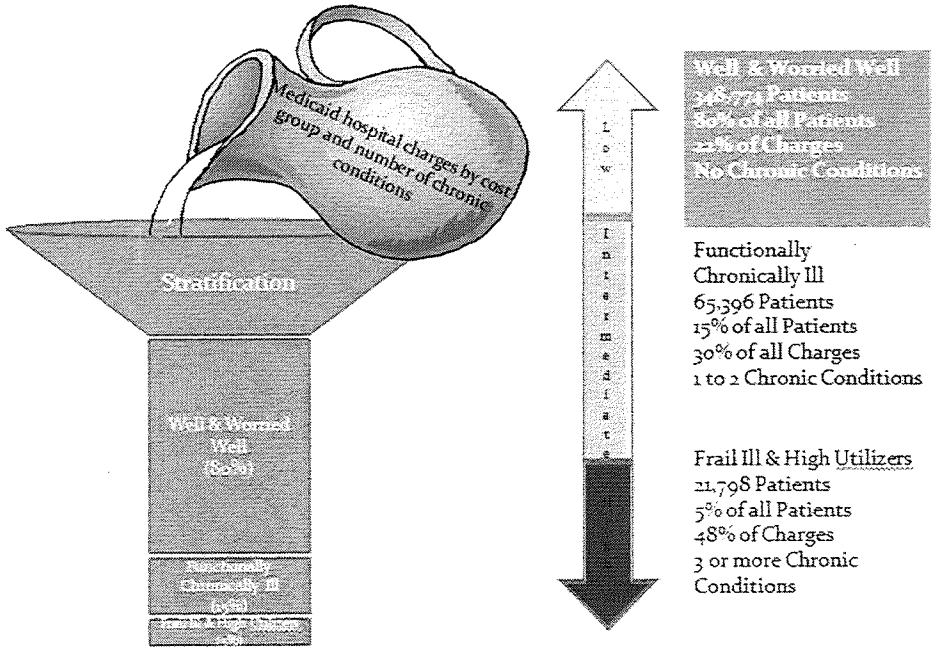
The Need for Better Management of Chronically Ill Patients in Missouri Medicaid Managed Care Plans

Slide 1



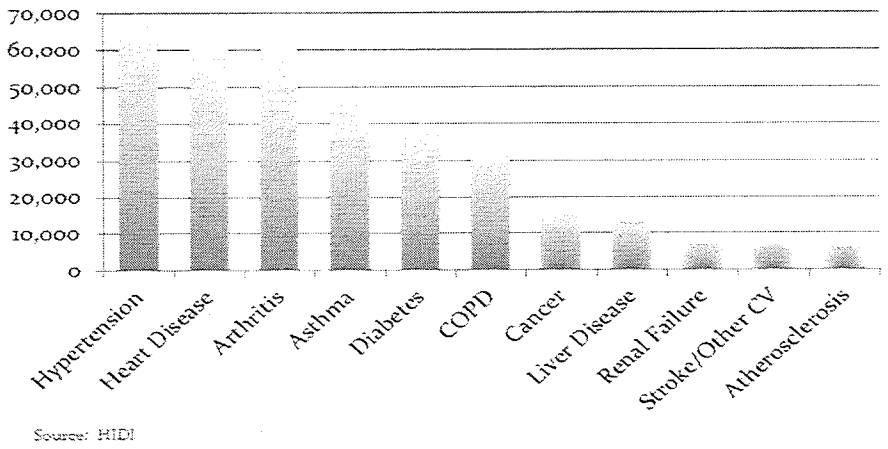
Slide 2

MO HealthNet Population Management Strategy



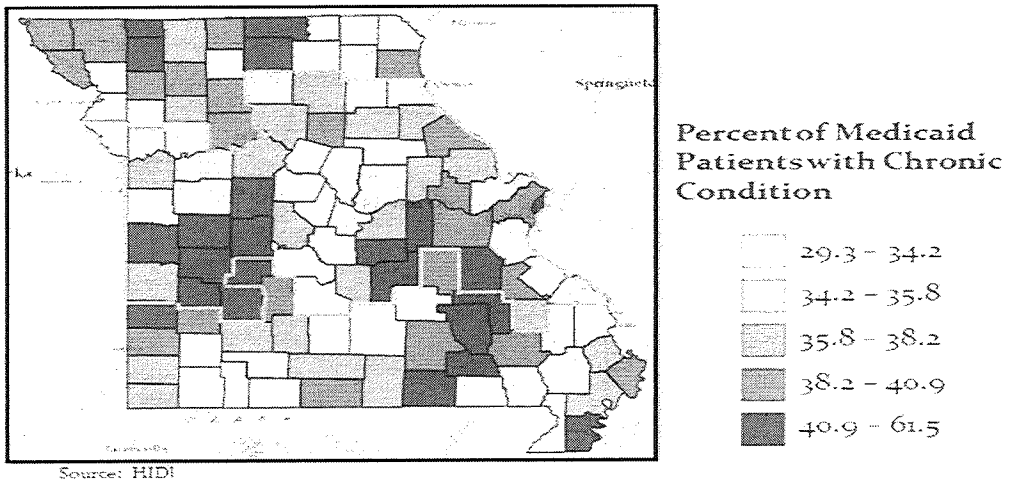
Slide 3

Prevalence of Chronic Conditions in Medicaid Patients



Slide 4

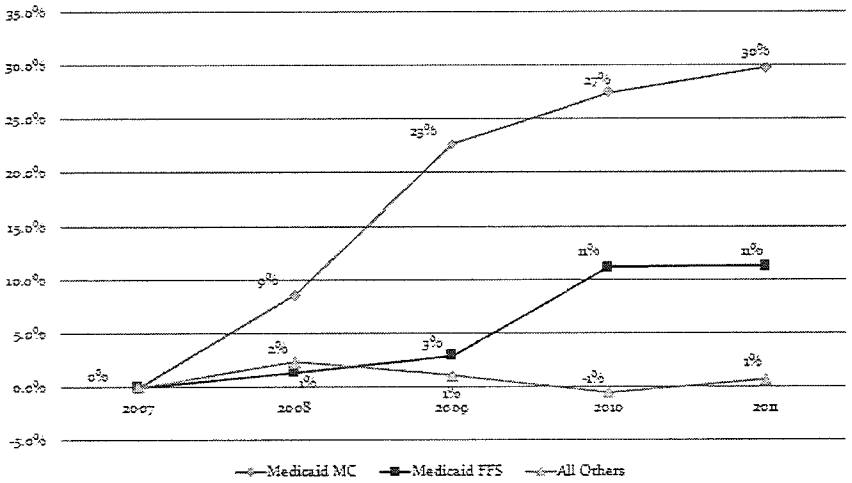
Geographic Distribution of Chronic Conditions in Medicaid Patients



*Testimony by Sally Nance, CEO Excelsior Springs Hospital, to the House Interim Committee on Citizens & Legislators Working Group on Medicaid Eligibility & Reform

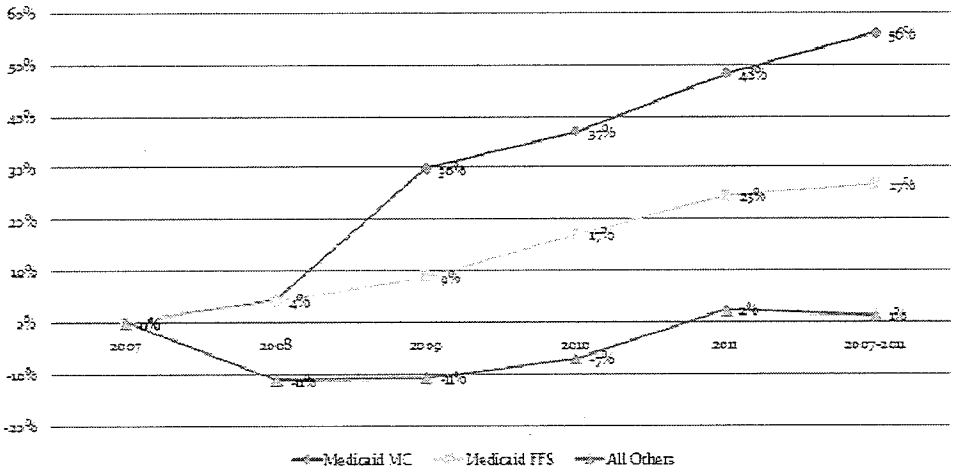
Slide 5

Total ED Visits Cumulative Percent Change by Payer: 2007-2011



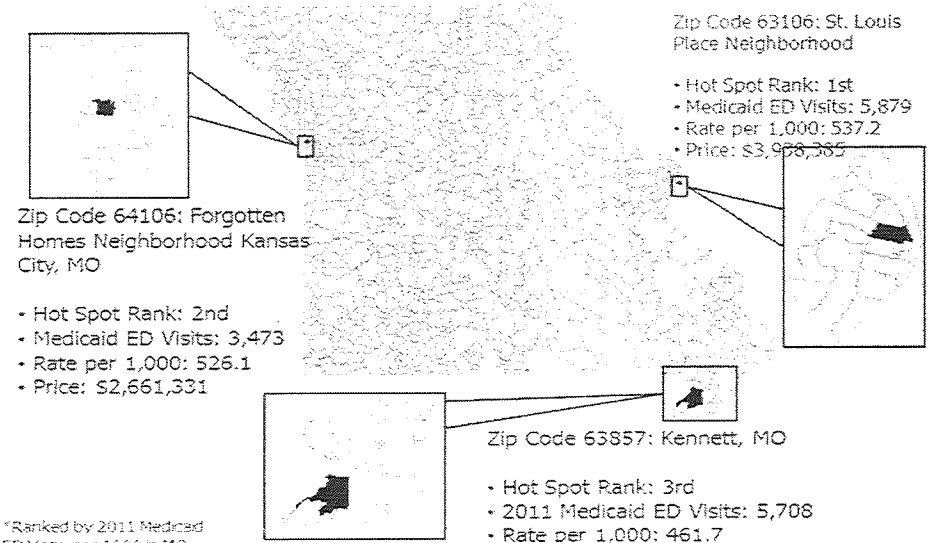
Slide 6

Non-Elderly Psychiatric ED Visits Cumulative Percent Change by Payer: 2007-2011



Slide 7

2011 Highest ED Frequent Flier Visits by Zip Code Located in Medicaid Managed Care Corridor: #1 St. Louis & #2 Kansas City

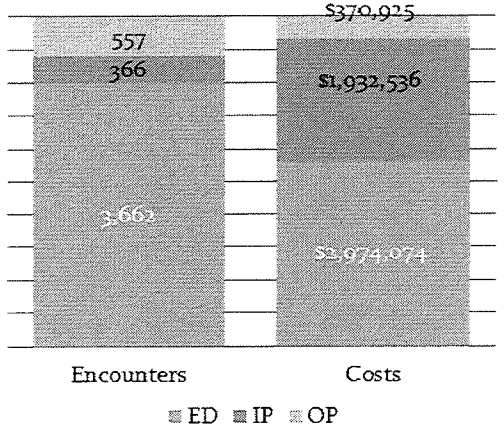


Slide 8

2011 Top 51 Individual Medicaid ED Frequent Fliers: (avg per beneficiary)

- 51 Individuals
  - 3,662 ED Visits (71.8)
    - $2,974,074 ($58,315)
  - 366 IP Stays (8.3)
    - $1,932,536 ($43,921)
  - 557 OP Visits (10.9)
    - $370,925 ($7,728)
- Total
  - 4,585 Encounters (90)
    - $5,277,535 ($103,481)

2011 Medicaid ED Frequent Fliers Encounters and Costs by Place of Service



*Testimony by Sally Nance, CEO Excelsior Springs Hospital, to the House Interim Committee on Citizens & Legislators Working Group on Medicaid Eligibility & Reform

Appendix 11: Comments by George Oestreich, PharmD, MPA

Citizens and Legislators Working Group on Medicaid
George L. Oestreich, PharmD, MPA, Member

The overwhelming majority of those testifying support Medicaid expansion. The Chairman's report does an excellent job sharing the background and perspective of those in support.

Those testifying in opposition largely fell into three main groups with some overlap. They were: the fear the federal government would not continue to support the promised 90/10 funding in out years; the state should improve the management of MO HealthNet prior to expanding coverage; and those fundamentally opposed to subsidized healthcare services except for all but the most impoverished and disabled.

There is no basis to support that the federal government would cease funding the program. There are also safeguards in place to further preclude the occurrence. Additionally the state could roll back the coverage should cost sharing schedule change or cease.

There was little specificity to support the need for fundamental reform of the Medicaid system. The issues brought out are functions of the statutory footing of the agency. Those, if the will exists, can be easy changed and are not a function of the current administrative agents. Some of those will be outlined below.

For those philosophically in opposition, I yield to my elected representatives to find the best solution. It is clear from a rational view that there is a significant number of Missourians that cannot provide insurance for themselves either because of poverty or because of underlying debility and/or chronic disease. As a healthcare provider, I believe reasonable access to reasonable preventive care and basic primary care is fundamental human need for which our government should assure access to its citizens.

MO HealthNet has pioneered a program focusing on healthcare homes for recipients with co-occurring behavioral health issues. This program is considered a model for other states to emulate and a model for cost effective use of resources resulting in positive patient outcomes. It is also a model of multidisciplinary collaborative practice among the other states. Part of the reform of the system should expand these proven policies to all of the Medicaid recipients.

Spend down should be reviewed and probably eliminated. It is inefficient to administer, not well defined, inconsistently administered and still leaves recipients with gaps in therapy. The gaps produce larger cost for the system and result in needless suffering by recipient.

One reasonable solution could be determined by reviewing and modifying the day certain eligibility. Maintaining a reasonable eligibility period would allow for a cohesive care coordination program to support transitional care and prevent unnecessary deterioration from chronic disease. A reasonable eligibility period would also provide the opportunity for health screenings to occur and care for emerging chronic disease to begin.

Evidence was presented that showed Mo HealthNet administration is far less than that of a comparative health insurer. However, MO HealthNet is short of trained clinicians to evaluate and

set policy but to also determine benefit design and support system integration. The false economy of too lean of a trained management staff is evident in several areas. This staff will be needed regardless of the delivery system. If MCOs are primary method of care organization the additional clinicians will be needed for oversight, outcomes evaluation and program guidelines development.

The overall administrative structure of MO HealthNet should be reviewed. MO HealthNet is a Division of the Department of Social Services, which is the single state agency. Many states have formed independent administrative organizations to administer their Medicaid programs. This would allow for a more accountable system and one created for the task of healthcare planning, funding and deliver.

Testimony was presented that if expansion occurred, physician resources would be further stretched and access to care may be threatened. Increased use of physician extenders was suggested (nurse practitioners and physicians assistants). Also available to meet this need are the recently passed collaborative practice measures for pharmacists. The value of these services to lower cost, increase patient outcomes and reduce physician time requirements is well documented. The expanded use should be encouraged.

The MO HealthNet pharmacy program was mentioned several times. The current pharmacy program was created legislatively in 2001. At that time after a thorough debate, the General Assembly supported creating the program in-house as opposed to contracting with a PBM, or any other third party payer. The breadth of the formulary is a byproduct of the federal rebate program and not a state option.

The pharmacy program implemented "first in class" services over its 10 years in existence that are emulated by many other states. Some of those services are: clinical edits targeted at specific patient needs which produce the lowest cost agent for the patients specific need; supplemental rebates that produce a preferred drug list yielding lower cost and higher rebates; integrated paid claim tool that allow any MHD provider to see a patients treatment allowing coordination of care; and the integration of the pharmacy program with other MHD programs allowing all to share discrete patient data.

The pharmacy program is cited in a recent Lewin study as one of the best in the nation. It is far more sophisticated than any of the pharmacy benefit managers and operates on a far smaller budget. Claims are adjudicated transparently the majority of the time. Two legislatively created bodies review the criterion for the edits openly in open session.

By carving out the pharmacy benefit from the managed care contracts that exist to administer Medicaid benefits in the I-70 corridor, not only does the state receive a more efficient, robust, and technologically superior service it is also able to administer a pharmacy tax. This tax is similar to the hospital, nursing home, and ambulance tax. This tax generates over $60 million in General Revenue look-alike funds that allow the state, with federal match, to purchase more than $150 million in drugs and pharmacy services. This reduces the need for state appropriations by almost 50% for the pharmacy program. This tax would not be possible if the pharmacy benefit was carved in or administered by a PBM. In fact a fiscal note on a 2013 House Bill proposed to eliminate the "carve out" resulted in a nearly $100M fiscal note to the detriment of GR.

Appendix 12: Comments by Leanne Peace, MSW, LCSW, MHA

Summary of the Citizens & Legislators Working Group on Medicaid Eligibility and Reform

Committee member: Leanne Peace, MSW, LCSW, MHA and Director of MO Kidney Program.

Sept. 5, 2013

I am honored to have served on this summer's working group to study this very important subject, and appreciate this opportunity to help shape Missouri's consideration of Medicaid expansion. As a 25 + year medical social worker, who has worked with the chronically ill kidney population, I wholeheartedly support full Medicaid expansion. I truly believe this is an opportunity to provide vital and effective preventive care. Many of my low-income patients that are on dialysis were not able to have medical care, or afford their expensive hypertensive medications or diabetic insulin/syringes/strips over the years. Consequently they eventually ended up on a very expensive, life-long debilitating treatment regime. Full Medicaid Expansion will be in the best interest for our citizens, and the state government's economic interest.

I do believe that after the extensive testimonies heard, that MO citizens overwhelmingly want full Medicaid Expansion. However, there are some important changes that could be implemented to make this a better and efficient system. These changes were expressed repeatedly by numerous witness testimonies around the state.

1. Improve the Spend Down system. It is too labor-intensive for the FSD workers, too cumbersome for the providers, and too confusing and medically harmful for the patients.
    a. One solution would be to increase it to a 3 or 6 month coverage period. This would reduce FSD and provider workload, but more importantly reduce the break of the continuity of care for patients.
    b. For duel eligible patients (those with Medicare and Medicaid), increase the Aged, Blind, Disabled guidelines to at least 150% or 200% of FPL.
2. Incentify work by improving the Ticket to Work program. People want to work, but can only do so when they are not threatened by losing vital healthcare coverage. Ticket to Work needs to offer a reasonable "buy-in" option to TTW, or to have higher tiers of eligibility, so that patients do not have refuse raises, promotions or increase hours.
    a. Raise monthly premium participation from 100% of FPL to 250%.
    b. Raise net income limit from 85% to 138%
    c. Raise asset limit from $1,000 (individual) to $5,000.
3. Increase personal responsibility by using positive incentives instead of increasing co-pays or premiums.
    a. Incentify healthy behavior by offering smoking cessation programs, weight management programs, and exercise plans. (similar to private insurance industry)
    b. Reduce unnecessary ER visits, by identifying the "Super users" and offering them case management or perhaps establish the services of a free 24/7 Nurse Triage call. The nurse could determine if an ER visit is essential, and if not, then set up a primary care appointment during business hours, plus provide transportation.

4. Increase Provider rates so would be willing to accept these critical patients
5. Reduce legal restrictions of Nurse Practitioners or Advanced Practice Nurses, especially in the rural settings.
6. Expand the Medical Home model for both the chronically ill and those with behavior health needs.
7. Eliminate the FSD Reorganization plan which will limit FSD Eligibility Worker availability and hamper provider and customer service. Do NOT expect many of the ABD patients to be able to successfully use kiosks, or toll free recordings for such a complicated application and renewal process.
    a. Provide an efficient consumer friendly structure, with forms and letters that are easy to read, understand and complete. Suggestion: partner with Health Literacy Missouri.
    b. Increase the # of days to respond to patient annual renewals from an unrealistic 10 days to a reasonable 30 day turn-around time.
    c. Return to the face-to-face interaction availability of Eligibility Workers.
    d. Reduce the paperwork burden on provider billers, so they would be more willing to accept Medicaid clients.

Appendix 13: Comments by Steve Pu, DO

Rep. Torpey,

I would first like to thank you for allowing me to serve on this important committee, and to participate in the conversation. It was both informative, and interesting to listen to not only the witnesses, but to the other participants. I do hope that something meaningful will arise from the many hours of effort put in by everyone. As you repeated so many times, let's keep an open mind. Here are some of my thoughts about what I heard.

1. Medicaid is a complex, emotional issue that we need to address sooner rather than later. It is apparent that reform and expansion are needed. It is my opinion that these are not mutually exclusive endeavors, and they can occur simultaneously. Reform will take years, but the process needs to begin now. Expansion can occur now, and should occur in this window of opportunity, even if it is not sustainable. There is too much compelling evidence that the benefits outweigh the risks, at this point.
2. There is obvious fraud and abuse in the system, the degree is what is in question. Whether it is major or minor, this needs to be addressed, and stopped. It also seems apparent that there is a lack of accountability in some of our state government agencies, and this needs to be corrected.
3. We have a multitude of various programs within the Medicaid system, with their own eligibility requirements. The overall system needs to be evaluated, and some consolidation needs to be considered.
4. We need to really look at various models of care delivery that make sense, and produce efficiency, and most importantly, better outcomes. Healthier Missourians with ultimately result in major cost savings to the state. The Patient Centered Medical Home model seems to hold great promise, and early data shows improved outcomes with cost savings. Also encouraging is that they seem to be effective in both the rural and urban settings. These need to be expanded, and studied further to determine if this is ultimately the model that needs to be moved to all communities. Although the initial data is encouraging, I would fall short of recommending full implementation yet.
5. We must begin to address the present as well as future workforce shortage, particularly in relation to primary care. We heard compelling data from the AHEC's on the rural pipeline that has produced many primary care providers for rural Missouri. These programs need to be supported, and expanded to meet the needs of our state. Obviously though we will not be able to produce an adequate number of primary care physicians to serve the growing need, particularly with Medicaid expansion. We must find a way to expand the role of APN's in the state. There is significant resistance by the state medical societies, but the reality is we will not produce the number of physicians to serve the expanding population. We need constructive, open, and respectful dialogue between nursing groups, and physicians groups to work on a compromise to better serve our most vulnerable Missourians. I would not forsee that Chiropractors would be able to fill these gaps. They are important providers of care, but don't think it is in primary care.
6. Health literacy is and will continue to be a huge issue in healthcare. It is well known that low health literacy is a major factor is wasted dollars, and poor outcomes for all populations. It is

estimated by improving health literacy, we could save billions yearly in healthcare dollars. It doesn't stop there. With improved health literacy, we can empower patients to actually make better choices about their health because they will be able to understand better the consequences of their decisions. It will give us the opportunity to actually make people take more personal responsibility for the decisions they make. As we look at delivery models for the future, we must include health literacy, with clear communication, and plain language information for our patients.

7. We heard at every hearing about the problems with the spend down program. Although well intended, it appears obvious there needs to some changes made to prevent people from having to make too many tough decisions on food vs meds.
8. It was very disturbing to hear the audit report concerning the recert process, or lack of process. As stated before, this is an accountability issue, but we must be sure this process is not neglected. Drug testing of recipients remains a practical and good idea, but perhaps we could replicate a similar model as CMS does with hospitals in RAC audits. In this process, outside vendors are contracted to determine fraud, and if proven, they would recoup a percentage of the potential savings. The state doesn't really have the manpower to monitor this adequately, so looking at contracting outside vendors may provide the manpower the state does not have.
9. One of the most exciting projects I heard was in St. Louis from Dr. Jotte about a program to strictly case manage the super utilizers. This could potentially save the state millions of dollars in avoidance of ER visits alone. Very anxious to see how this study develops. There is good case management built within the Medical Home model, but for the superutilizers more is needed.

Finally, I do not envy the position that you are in at the present time. As exhibited in the hearings, sometimes it is difficult to separate the emotion from the facts, but as elected officials you must make the difficult decisions. In 2005, legislators made a very tough vote to scale back Medicaid eligibility to 19% FPL, and what is lost in the conversation is it did allow the state to remain financially sound when neighboring states were struggling to pay their bills. Now though is the time to move forward, and use our tax dollars to assist the actual people who work, pay taxes, and try to be productive, the working poor. Although we all can agree we don't trust the federal government, there are times when we must take a leap of faith for the good of our great state. I truly believe this is one of those times.

Once again, it has been an honor to serve on the committee, and I hope I was able to contribute to its ultimate goal. If I can ever be of further assistance, please let me know.

Sincerely,

Steve M. Pu, D.O.

Appendix 14: Comments by Ed Weisbart, MD

Missouri House Interim Committee on
Citizens and Legislators Working Group on Medicaid Eligibility and Reform
Insights from 2013 Public Hearings – Ed Weisbart MD

Citizens across the state want the legislature to fully expand Medicaid immediately.

86% of witnesses spoke in favor of expansion of Medicaid.

1,750 witness forms in favor of expansion were submitted on August 14, 2013.

	For expansion	Against expansion	Informational	Total
July 10 - Independence	2	0	2	4
July 16 - Springfield	21	0	2	23
July 27 - Columbia	39	2	2	43
July 31 - Kennett	33	3	2	38
Aug 7 - Cameron	11	2	8	21
Aug 14 - St. Louis	70	5	2	77
Total	**176**	**12**	**18**	**206**

Recommendations

- *Full expansion of Medicaid is transformational and should be done immediately, ongoing with other improvements.* Delaying expansion is damaging to public health and statewide economics.
- The Medical Home models have proven themselves effective for both primary and mental health care. They should be continued and expanded.
- Change the "spend-down" process to a six-month cycle rather than the current one-month process.
- Increase access to primary care providers
    - Support various state initiatives (e.g., MAHEC) to grow the primary care base
    - Reimburse providers at a competitive rate to encourage them to accept Medicaid patients into their practices
    - Carefully expand the role of nurse practitioners within MO.
- Coordinate care more closely across other state programs such as those delivered through the correctional systems.
- Streamline and strengthen both the eligibility and audit processes.
    - Build in presumptive eligibility
    - Identify select disabilities that would reasonably be expected to either longer or shorter than the current process.
        - Some incurable conditions, like most forms of blindness or paraplegia, should not require periodic re-assessments. Consider assigning them "lifetime disability" status.

        - Others might be anticipated to improve significantly with treatment, e.g., some forms of back pain.

- Correct the perverse incentives that today penalize the disabled from working. For example, improve upon the "Ticket to Work" program.
- If the state preserves and grows the role of managed care in Medicaid, much more oversight is needed.
    - Require independent actuarial reports that demonstrate the complete cost of outsourcing MOHealthNet in this manner as compared to what it would cost to manage Medicaid internally by a well-resourced staff.
    - Align private and public sectors with a single set of standards and performance metrics.
        - As suggested by the STL Business Health Coalition, get baseline metrics and set clear performance goals for all plans in Missouri, public as well as private. Such metrics are inexpensive to collect and most already have industry benchmarks.
        - In addition to a defined set of common metrics for all payers, develop additional performance metrics for those payers who are required to provide additional services to their beneficiaries.
        - Reach out to community resources and appoint a small oversight committee to develop and monitor the above metrics and report back to the legislature on progress made towards legislature-established goals at pre-determined intervals.
- Develop a strategic plan to better support and coordinate the care of "super-utilizers".

Appendix 15: Comments by Jane Whitesides

Missouri House Interim Committee on Citizens and Legislators Working Group on Medicaid Eligibility and Reform

Jane Whitesides, Committee Member

More than 85% of the testimony offered was overwhelmingly in favor of expansion, and while there were some suggested reforms, most were changes that could be made to the current Medicaid program.

While there may well be good reasons against expanding Medicaid and good options for improving health care access and delivery in Missouri, the few (12) who spoke against expansion did not offer such arguments. They merely said that Medicaid is broken without giving clear examples of needed reform. We did not hear from providers or recipients that Medicaid is broken. It seems that the biggest problem with Medicaid is that it does not *cover enough people in Missouri.*

There were some areas where we had little or no testimony, and it would be helpful to pursue information in these areas.

1. More provider input about the managed care model as opposed to the fee for service model. It seems that the out of state managed care providers can be problematic for efficient and effective patient care. Any expansion of the managed care model will need more oversight by the State.

2. Durable medical equipment providers did not provide testimony but will be impacted by expansion. These businesses frequently see some of their clients unable to pay for needed equipment and services because they have not met their spend down. There are illogical exemptions for some equipment and therapies

3. There was little testimony about the differences in treatment for the insured versus the uninsured in the emergency room, but these differences have an impact on health outcomes and raise costs over time. Disparities in treatment make a very compelling argument for getting people insured.

Some of the reforms put forward dealt with:

- Increasing the development of health homes, because the outcomes in terms of better health are encouraging. These models can be expanded to work better with superutilizers, also.
- Working to insure toward continuous coverage, so that patients have no gap in coverage. This may be addressed by changing qualifying eligibility time periods.
- Ticket to Work Health Insurance needs to be expanded, allowing for more enrollment and for enrollees to work more and keep their insurance.
- Reforming spend down without lowering eligibility, but making sure patients get the care, services, and equipment they need. Patients who miss a critical doctor's appointment because they have not met their spend down may precipitate a health crisis, resulting in poorer outcomes and higher costs.

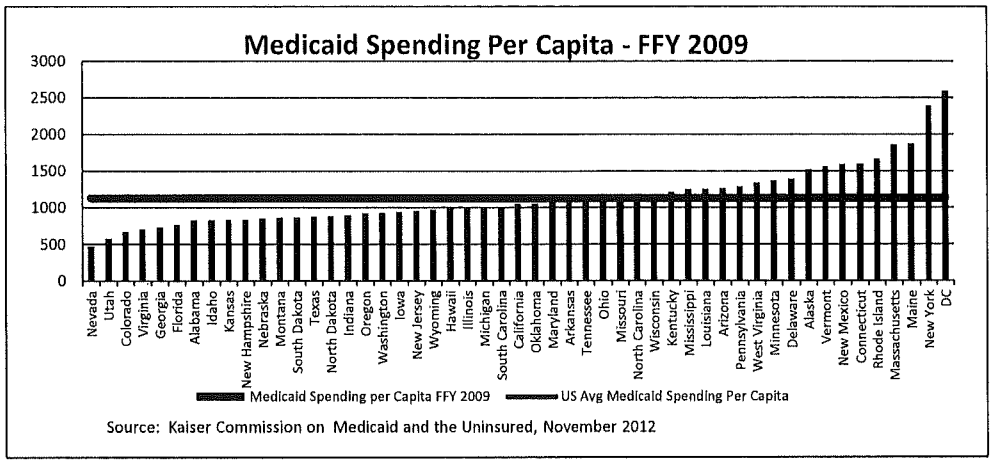
We should offer robust support for increasing primary care physician availability, especially in rural areas, and for expanding the role of nurse practitioners under supervising physicians. Both are critical to the success of the expansion of Medicaid and health outcomes for all Missourians.

Conclusion: Missouri has over 800, 000 uninsured residents. We should be focused on covering more Missourians, because access to care means a healthy, productive work force and more stable families. The expansion of Medicaid is the first reform, and does not in any way deter other needed reforms.

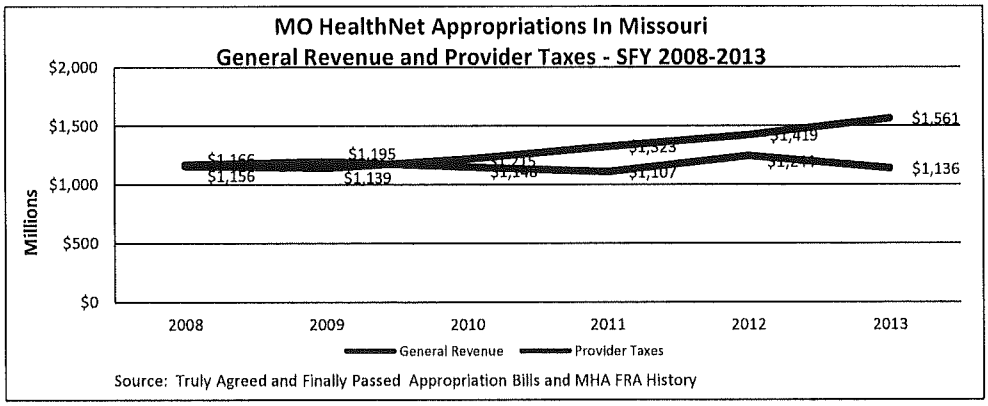
Appendix 16: Comments by David Zechman

MEDICAID REFORM/EXPANSION RECOMMENDATIONS

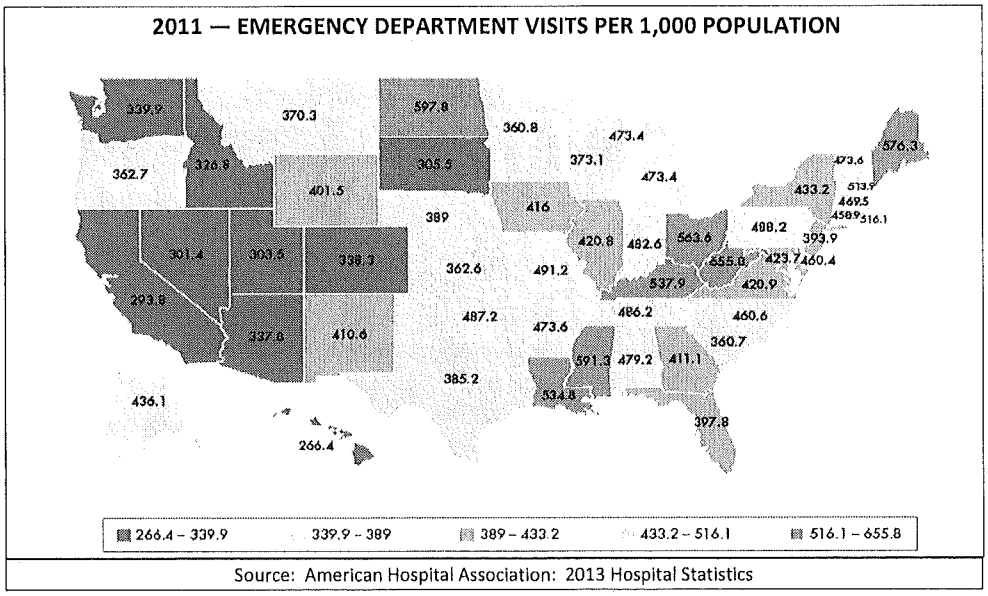
- **Some parts of Missouri's Medicaid Program work well, but more efficiencies can be found** — costs are in line with national norms, general revenue obligations are low and stable thanks to provider taxes. However, adult eligibility is among the lowest in the country — 18 percent of federal poverty level. This means too many people use the emergency room for their health care needs.



Source: Kaiser Commission on Medicaid and the Uninsured, November 2012



Source: Truly Agreed and Finally Passed Appropriation Bills and MHA FRA History



Source: American Hospital Association: 2013 Hospital Statistics

- **Medicaid Reforms already being tested in Missouri show great promise in reducing costs (particularly reducing emergency room visits) through better care management**— MO HealthNet has been effective in using new technology and other states experiences in containing costs and exploring care management interventions. We know good care management is effective in containing costs while improving health outcomes. We know what works for Missouri. Below see a list of successful initiatives managed by MO HealthNet. We need to bring these efforts to an appropriate scale to maximize their benefit.

  - Missouri Gateway To Better Health
  - Health Homes
  - Pursuit Of Waste, Fraud And Abuse
  - 340B Drug Repricing
  - Missouri State Medicaid Health Information Technology Plan\Managed Care Quality And Rates
  - Provider Preventable Conditions
  - Primary Care Rate Increase
  - Early Elective Delivery
  - MMIS Procurement
  - CMS Initiative To Reduce Hospitalizations Among Nursing Facility Residents
  - CMS Medicaid Emergency Psychiatric Demonstration Project
  - Long Term Care Modernization Project

- **The working poor with household income below 100 percent FPL will be left out of a health insurance market absent Medicaid Reform/Expansion.** The Affordable Care Act remains the law of the land. Missouri will have a federally facilitated exchange in 2014, with subsidized coverage for working families with household income between 100-400 percent of FPL. It is good public policy to keep those that are working healthy, making Missouri a more productive state. Twenty-five other states[1] have found a path forward to create an opportunity for coverage for these working families. Missouri should too.

- **Medicaid Reform/Expansion costs are fully paid by CMS through 2016 and the state share will never exceed 10 percent. Additionally, the Missouri Office of Administration economic forecasts predict the impact on state General Revenue Budget of this 10 percent state share cost to be budget neutral or positive through the year 2021.** Hospitals are facing cuts in Medicare and Medicaid reimbursement of $4.2 billion[2] between 2013 and 2020 whether or not Missouri reforms/expands Medicaid. In contrast, Medicaid reform/expansion will result in Missouri federal tax dollars returning to Missouri[3], supporting new jobs[4] and generating new tax revenue for the state general revenue fund[5].

- **Chambers of Commerce around the state have endorsed Medicaid Reform/Expansion[6]**. They understand how the impact of providing hospital care to the uninsured results in a cost shift to their bottom lines — the hidden health care tax, expected to reach $3.5 billion by 2019[7]. They know Medicaid coverage will help businesses meet their new obligations to offer coverage — or pay a penalty — under the affordable care act. They also know this will improve the health of working Missourians who are currently uninsured, and therefore increase productivity.

Medicaid reform/expansion is good for Missouri taxpayers; it's good for hospitals; it's good for business. And of course it's good for the individuals and families who can lead more healthy and productive lives.

Chairman Torpey Committee Member Report Submitted By David Zechman, President and Chief Executive Officer, Ozarks Medical Center, West Plains, Missouri

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[1] https://www.statereforum.org/tracking-medicaid-expansion-decisions - August 28, 2013

[2] http://www.missourihealthmatters.com/2013-03/articles/%E2%80%98hidden-health-care-tax%E2%80%99-costs-missouri-businesses-billions-annually/

[3] http://mobudget.org/files/Medicaid_Expansion_Rural_1-2013.pdf

[4] http://web.mhanet.com/media-room/news-releases/medicaid-expansion-creates-jobs-grows-missouris-economy

[5] http://content.oa.mo.gov/budget-planning/budget-information/2014-budget-information

[6] http://www.mochamber.com/mx/hm.asp?id=031313medicaid

[7] http://web.mhanet.com/media-room/news-releases/hidden-health-care-tax-looms-medicaid-reform-could-ease-burden